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No. 09-24

Supreme Court, U.S.
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In The
Supreme Court of the United States

AMERICAN FAMILY MUTUAL INSURANCE COMPANY and AMERIPREFERRED PPO PLAN,

Petitioners,

v.

SHARON MONDRY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Respondent, Sharon Mondry, filed a claim for reimbursement of speech therapy expenses for her son from the ERISA-governed health benefits plan provided by her employer, American Family Mutual Insurance Company. CIGNA, the claims administrator, denied Respondent's claim for benefits. The Respondent then requested plan documents from CIGNA and American Family, as well as documents related to her appeal. American Family provided the Respondent with its Summary Plan Description. CIGNA initially refused to provide an internal guideline relied upon in denying the Respondent's claim, which guideline American Family did not have. CIGNA eventually provided the Respondent a copy of its internal guideline, and thereafter reversed its decision to deny her claim for benefits. The internal guideline used by CIGNA conflicted with the controlling terms of American Family's health benefit plan.

The Respondent seeks penalties from American Family for failing to promptly provide a copy of CIGNA's internal guideline so that she could pursue a full and fair review of the denial of her claim. The Respondent contends that the improper internal guideline relied upon by CIGNA constituted a document under which American Family's ERISA plan was operated and should have been produced like other plan documents. The Respondent also contends

QUESTIONS PRESENTED – Continued

that the claims handling agreement pursuant to which American Family hired CIGNA to process claims constituted a plan document that should have been provided to plan participants.

The issues presented for review are:

1. Do internal claims handling guidelines that conflict with the terms of an ERISA-governed health benefit plan thereby morph into documents under which the plan is operated if relied upon in error by a third party claims administrator?

2. When a plan administrator hires a third party to process and decide benefit claims, is the claim administration agreement a plan document that must be provided to plan participants even if the agreement does not define or explain the rights of participants or create any incentive for the third party claims administrator to deny claims?

PARTIES TO THE PROCEEDINGS

The Petitioners are American Family Mutual Insurance Company and AmeriPreferred PPO Plan. The Respondent is Sharon Mondry. Connecticut General Life Insurance Company was a party to the Appeal in the Seventh Circuit, but is not a petitioner for a Writ of Certiorari.

CORPORATE DISCLOSURE STATEMENT

American Family Mutual Insurance Company has no parent corporation. No publicly held company has any ownership interest in American Family, which issues no stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully request that a writ of certiorari issue to review the final judgment of the United States Court of Appeals for the Seventh Circuit.

OPINION BELOW

The opinion of the United States Court Appeals for the Seventh Circuit is reported at *Mondry v. American Family Mutual Insurance Company*, 557 F.3d 781 (7th Cir. 2009). The Seventh Circuit reversed the November 22 and December 12, 2006 decisions of the United States District Court for the Western District of Wisconsin. *See* Appendices B-C (App. 64-105).

STATEMENT OF JURISDICTION

The Supreme Court has jurisdiction under 28 U.S.C. §1254(1). The Seventh Circuit's opinion was rendered on March 5, 2009. *See* Appendix A (App. 1-63). Petition for Panel Rehearing and Suggestion for Rehearing En Banc was filed on March 19, 2009. The Petition for Rehearing was denied on April 2, 2009. *See* Appendix D (App. 106).

STATUTORY PROVISIONS INVOLVED

Title 29 United States Code, Section 1024(b)(4)

Filing and Furnishing of Information

The administrator shall, upon written request from any participant or beneficiary, furnish a copy of the latest updated Summary Plan Description, and the latest Annual Report, any terminal report, the Bargaining Agreement, Trust Agreement, Contract or other instruments under which the Plan is established or operated.

Title 29 United States Code, Section 1132(c)(1)(B)

Civil Enforcement

Any administrator . . . who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within thirty days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100.00 a day from the date of such failure or refusal, and the court may in its discretion order such other further relief as it deems proper. For purposes of this paragraph, . . . each violation described in

subparagraph (B) with respect to any single participant or beneficiary shall be treated as a separate violation. [By regulation, the maximum permissible penalty under §1132(c)(1) has been increased to $110.00 per day. 29 C.F.R. §2575.502c-3.]

STATEMENT OF THE CASE

The Respondent filed a claim for benefits under the employee benefits plan of American Family. The third party claims administrator of the benefit plan, CIGNA, initially denied the Respondent's claim for benefits. The Respondent appealed CIGNA's denial of benefits, and she ultimately prevailed in her administrative appeal.

The Respondent then commenced the present lawsuit against American Family and CIGNA claiming that they had breached disclosure obligations under §1024(b)(4) of ERISA. The Respondent also claimed that American Family and CIGNA breached fiduciary duties owed to her and she sought compensatory damages under §1132(a)(3). Finally, the Respondent claimed that American Family committed acts of racketeering, mail fraud, and wire fraud.

The district court dismissed the Respondent's claims against CIGNA for failure to state claims upon which relief may be granted. The court held that the obligation to provide plan documents falls only on

plan administrators, not claims handling administrators like CIGNA. The court also dismissed the Respondent's RICO, mail fraud and wire fraud claims against American Family for failure to state claims upon which relief may be granted.

American Family subsequently moved for summary judgment, seeking dismissal of Respondent's remaining claims. The district court granted summary judgment dismissing the Respondent's breach of fiduciary duty claim against American Family. The court also decided that American Family did not have an obligation under §1024(b)(4) to provide the Respondent with American Family's claims administration agreement with CIGNA. The court, however, ruled that American Family did have an obligation to produce CIGNA's claims handling guidelines under §1024(b)(4).

American Family moved the district court to reconsider whether CIGNA's claims handling guidelines constituted plan documents. The court granted American Family's motion for reconsideration, thereby granting summary judgment in favor of American Family and dismissing the Respondent's action in its entirety.

The Respondent appealed the district court's judgment dismissing her complaint. The Respondent argued that the district court erred by dismissing her ERISA disclosure claims under §1024(b)(4) against American Family and CIGNA. The Respondent also claimed that the court erred by dismissing her breach

of fiduciary duty claim against American Family and CIGNA under §1132(a)(3). The Respondent, however, did not dispute that the district court correctly dismissed her RICO, mail fraud, and wire fraud claims against American Family.

The Seventh Circuit Court of Appeals reversed the judgment of the district court dismissing the Respondent's complaint against American Family. The Court entered its decision on March 5, 2009. The Petitioners timely filed a Petition for Panel Rehearing and Suggestion for Rehearing En Banc on March 19, 2009, which the Seventh Circuit denied on April 2, 2009.

STATEMENT OF MATERIAL FACTS

The AmeriPreferred PPO Plan ("Plan") is a self-insured group health insurance plan offered by American Family to its employees. The Respondent previously was an employee of American Family and a participant in the Plan.

CIGNA was the third party claims administrator of the American Family plan and exercised discretionary authority in making claims determinations.

The Respondent's son received speech therapy services during the calendar year of 2003.

CIGNA denied coverage for the speech therapy services, stating that the services were not medically necessary. CIGNA's denial of coverage was allegedly

based in part on CIGNA's "Benefit Resource Tools Guidelines – Speech Therapy."

The Respondent timely appealed CIGNA's denial of coverage. The Respondent also requested "a complete copy of my Plan Documents. The document I was told to pull off the American Family Intranet site is a Plan Summary Description, and is incomplete."

CIGNA processed the Respondent's First Level Appeal, after which CIGNA upheld its original decision. CIGNA stated that the denial was based in part on the "CIGNA Clinical Resource Tool for Speech Therapy."

After the Respondent's first appeal was denied, she again wrote to CIGNA and American Family, requesting "a complete copy of my CIGNA Plan Documents." The Respondent's attorney also subsequently wrote to CIGNA and American Family, requesting "a copy of the Plan Document in effect at the time the coverage was denied for this claim."

American Family then wrote to the Respondent enclosing a copy of the AmeriPreferred's Summary Plan Description. American Family advised the Respondent that the Summary Plan Description was American Family's only plan document and that American Family did not have a separate plan document. American Family also reminded the Respondent that the Summary Plan Description was given to the Respondent in both paper and electronic form while she was an active employee and a paper copy

also was previously provided to the Respondent in response to an earlier request.

Respondent's counsel wrote to the Appeal Coordinator at CIGNA, requesting clarification as to whether American Family's Summary Plan Description was the "legally binding Plan document in effect at the time the coverage was denied for this [Respondent's] claim."

Respondent's counsel later wrote to CIGNA and American Family again, alleging that "American Family Insurance has failed to provide the complete Plan document." Respondent's counsel also complained that CIGNA "ignored several requests for the CIGNA Clinical Resource Tool for Speech Therapy and copies of all documents, records, and other information relevant to Ms. Mondry's appeal for benefits." Respondent's counsel then demanded "a copy of the legally binding Plan document in effect at the time the coverage was denied for this claim, a copy of the above-mentioned Clinical Resource Tool, as well as any other information used to make the decision to deny these services."

Respondent's counsel further wrote to CIGNA on January 28, 2004, suggesting that the Summary Plan Description was incomplete because the words "Expressive Language Delays" are not found in the Summary Plan Description, "so they must exist somewhere in Plan documents that have been withheld." CIGNA had used this language in denying coverage.

Finally, Respondent's counsel faxed another request for a plan document because "we have not yet received a plan document from American Family or CIGNA." The Respondent acknowledged, however, that she had the American Family Summary Plan Description. In addition to requesting a plan document, however, Respondent demanded "the rules, guidelines, or protocols used as the premise for the denial of services." Respondent's counsel also left a voice message at American Family requesting a hard copy of the "Clinical Resource Tool for Speech Therapy," referenced in CIGNA's benefits denial letter to the Respondent.

American Family advised Respondent that American Family would itself contact CIGNA seeking a copy of the clinical resource tool used by CIGNA to evaluate Respondent's claim for coverage of speech therapy services for her son. Respondent admits that American Family also advised her that the Summary Plan Description was American Family's only plan document.

American Family did call CIGNA to request that CIGNA's Clinical Resource Tool for Evaluating Speech Therapy be provided to the Respondent. CIGNA informed American Family that the Clinical Resource Tool was proprietary and that CIGNA would not release the information to the Respondent or to American Family.

American Family subsequently contacted the Respondent again to advise that CIGNA's tool for

evaluating speech therapy claims would not be released by CIGNA to either American Family or to the Respondent. American Family also gave the Respondent a contact name and telephone number at CIGNA to call.

American Family, as a matter of fact, did not have the requested CIGNA tool for evaluating speech therapy claims. Although American Family did not have the Clinical Resource Tool apparently used by CIGNA in evaluating Respondent's claim for benefits, however, American Family requested the document from CIGNA; American Family was not successful in obtaining the information requested on behalf of the Respondent, but advised Respondent of this fact and directed her where to personally call CIGNA.

The Respondent thereafter continued communications with CIGNA, demanding documents related to her appeal. Respondent's counsel eventually received the "CIGNA HealthCare Benefit Interpretation Resource Tool for GSA 2001 Requested Service: Speech Therapy."

On April 13, 2005, a Level Two Administrative Appeal Hearing occurred, after which CIGNA reversed its initial decision and authorized reimbursement for speech therapy services provided to Respondent's son.

The Respondent commenced the present action on June 14, 2006, against American Family and CIGNA, alleging a variety of claims, including allegations that American Family failed to provide the

Respondent with a copy of the contract or other instruments under which the plan was established or operated. The Respondent also alleged that American Family breached fiduciary duties owing to her by misrepresenting the terms and administration of the plan and by withholding information necessary to support the claims at issue and to perfect her appeal.

The Clinical Resource Tool for Speech Therapy utilized internally by CIGNA was not a document that American Family had or could obtain from CIGNA. American Family also did not participate in making the decision to deny Respondent's request for coverage of speech therapy services. CIGNA provided claims administration services to American Family – and American Family did not actively participate in the approval or denial of participant requests for benefits. American Family did not act with any intent to prevent the Respondent from pursuing her appeal of CIGNA's benefit denial. American Family provided the Respondent the applicable plan document, but information relating to criteria applied by CIGNA to determine medical necessity was developed by CIGNA and such information was not known to American Family.

CIGNA denied coverage for speech therapy services because they were deemed to be not medically necessary. "Medically Necessary" was defined in American Family's Summary Plan Description as follows:

Medically Necessary

> In addition to the reasonable and customary limits, to be eligible for Plan payment, medical services and supplies must be considered by CIGNA to be "Medically Necessary." For purposes of this Plan, Medically Necessary means that services and supplies are provided by a hospital, doctor, or other licensed medical provider to treat a covered illness or injury. The treatment must be appropriate for the symptoms or diagnosis, within the standards of acceptable medical practice, the most appropriate supply or level safe for the patient, and not solely for the convenience of the patient, doctor, hospital, or other licensed professional.

Respondent's counsel was aware of the terms of the Summary Plan Description, which terms were quoted extensively in Respondent's administrative appeal, including sections from the Summary Plan Description explaining "Medically Necessary," "Medical Services," "Covered Medical Services," "What the AmeriPreferred PPO Plan Does Not Cover," and "Claim Appeals."

REASONS FOR ALLOWANCE OF THE WRIT

1. The Seventh Circuit's decision conflicts with the holdings of other circuits and disregards concerns previously recognized by the Supreme Court. The Seventh Circuit's conclusion that internal claims

handling guidelines constitute plan documents conflicts, in particular, with the holdings of the First Circuit, as well as prior decisions of the Seventh Circuit. No Circuit has previously held that internal guidelines constitute plan documents.

Left undisturbed, the Seventh Circuit's decision in this case creates unresolvable uncertainty for plan administrators, which is likely to affect plan administrators across the country. This is an issue on which the Seventh Circuit's decision creates a split among the Circuit Courts and on which the Supreme Court's guidance is urgently warranted. The importance of the Supreme Court's resolution of the issues created by the Seventh Circuit decision is not limited to the present case.

The Seventh Circuit's decision conflicts with the Supreme Court's own recognition that the disclosure obligation of plan administrators under §1024(b)(4) is intended to implement ERISA's core functional requirement that employee benefit plans shall be established and maintained pursuant to a written instrument. "One of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time," which is implemented by an elaborate disclosure scheme built around reliance on the face of written plan documents. *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995). Plan administrators have a statutory responsibility to run the plan in accordance with the currently operative, governing plan documents. *Id.* at 84. This means that

reliance on standards that conflict with plan documents may invalidate a denial of benefits, but such an improper internal standard clearly does not constitute a plan document under §1024(b)(4).

The Seventh Circuit's holding that extraneous documents must be produced, such as inconsistent internal guidelines, also conflicts with the Supreme Court's recent recognition that plan administrators and beneficiaries should not have to look to extraneous documents to determine their rights and obligations. Importantly, ERISA requires plan administrators to discharge their duties in accordance with the documents and instruments governing the plan. The Supreme Court's recent decision in *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan*, 555 U.S. ___, 129 S. Ct. 865, 875 (Jan. 26, 2009), reinforced the long standing "plan documents rule" and reiterated the numerous reasons why it remains a bedrock principle of ERISA. The Court emphasized that by giving clear standards in a plan document, ERISA forecloses any justification for inquiries into extraneous, non-binding sources. "And the cost of less certain rules would be too plain. Plan administrators would be forced to examine a multitude of external documents that might purport to effect the dispensation of benefits." *Id.* at 876. In the present case, the Seventh Circuit's interpretation of the "plan documents rule" requires inquiry into extraneous documents, as well as documents that admittedly are inconsistent with the controlling plan documents.

The Seventh Circuit's decision misapprehends §1024(b)(4) by equating an ERISA administrator's disclosure obligation with the duty to disclose pertinent documents necessary for a full and fair review under §1133. The Court erroneously concluded that internal guidelines used by a claims administrator constitute "plan documents," even when the internal guidelines conflict with the provisions of a controlling ERISA plan. According to the Court, if a claims administrator expressly references internal guidelines in a decision denying benefits, and even if the claims administrator relied on the guidelines in error, then the guidelines constitute plan documents subject to disclosure under §1024(b)(4).

On the other hand, if a claims administrator does not expressly reference internal guidelines, but nonetheless erroneously relies on such guidelines, then the Seventh Circuit suggests that the guidelines "might" not constitute plan documents, which issue the Court declines to expressly decide. The Court suggests this distinction to avoid the weight of contrary authority, to which the Court cites. The Court relies on a distinction without meaning, however, even as a means to facilitate effective appeal rights by plan participants.

The Seventh Circuit's distinction would actually discourage claims administrators from disclosing internal guidelines when denying claims, which incentive runs contrary to the Court's stated objective to assure plan participants meaningful and transparent appeal rights under §1133. The disclosure obligation,

moreover, falls on plan administrators, and the obligation to disclose will differ depending on the vagaries of whether or not the claims administrator referenced the guidelines in denying a claim. This distinction makes no sense as to participants, and it is unworkable for plan administrators, who frequently do not even see claim denials.

The Seventh Circuit's decision ultimately conflicts with the Court's own decision in *Egert v. Connecticut General Life Insurance Co.*, 900 F.3d 1032, 1036 (7th Cir. 1990), which held that a claims administrator's internal guidelines are not part of an ERISA plan. The court's decision also conflicts with the First Circuit decision in *Doe v. Travelers Insurance Co.*, 167 F.3d 53, 60 (1st Cir. 1999), which expressly held that a plan administrator does not have an obligation under §1024(b)(4) to produce internal guidelines used to evaluate claims.

Finally, the Seventh Circuit's attempted distinction, between guidelines that are openly referenced by a claims administrator and guidelines not expressly identified, is unpersuasive. Guidelines in either situation do not override the controlling terms of an ERISA plan. Reliance by a claims administrator on guidelines inconsistent with the controlling terms of a plan may be arbitrary and capricious, but indicative that such guidelines are the antithesis of plan documents.

2. The Seventh Circuit's decision also misapprehends §1024(b)(4) by concluding that a plan administrator has a statutory obligation to disclose claims administration agreements, even when such agreements do not define the rights or benefits available to plan participants. The Court acknowledges that the claims administration agreement in this case does not apprise participants of their rights or benefits, but the Court concludes nonetheless that a claims administration agreement constitutes a document under which a plan is established or operated, such that it falls within the scope of §1024(b)(4). This holding conflicts with prior decisions, including *Fritcher v. Health Care Service Corp.*, 301 F.3d 811, 817 (7th Cir. 2002), in which the Court concluded that an administrative services agreement is not a "plan document."

The *Fritcher* decision relied on ERISA's basic purpose to afford employees an opportunity to inform themselves of their rights or obligations under a plan, which information the administrative services agreement did not provide. By contrast, in the present case, the Seventh Circuit's interpretation of disclosure obligations under §1024(b)(4) is divorced from the underlying rationale for disclosure, and the decision conflicts with the narrow scope of statutory disclosure recognized in prior decisions, such as *Ames v. American National Can Co.*, 170 F.3d 751, 758-59 (7th Cir. 1999), and other decisions. In this case, as in *Ames*, mandating disclosure of a claims administration agreement serves no practical purpose, even as a

means to facilitate a participant's full and fair review under §1133.

I. INTERNAL GUIDELINES THAT ARE ERRONEOUSLY RELIED UPON BY A CLAIMS ADMINISTRATOR DO NOT CONSTITUTE PLAN DOCUMENTS THAT DEFINE THE RIGHTS OR BENEFITS AVAILABLE TO PLAN PARTICIPANTS SUBJECT TO DISCLOSURE UNDER §1024(b)(4).

A. The Seventh Circuit Relies On A False Distinction.

The Seventh Circuit's decision purports to distinguish between internal guidelines expressly referenced by a claims administrator when denying a claim and the same guidelines when the claims administrator does not explicitly identify them. This is a false distinction. In both instances, as in this case, a claims administrator erroneously relies upon internal guidelines when they conflict with the terms of a controlling ERISA plan. Where the guidelines are referenced erroneously by the claims administrator, however, the Seventh Circuit concludes that they constitute plan documents under §1024(b)(4), but if the same guidelines are not expressly referenced by the claims administrator in denying a claim, then they might not be subject to disclosure by the plan administrator under §1024(b)(4), even if utilized by the claims administrator.

The Seventh Circuit makes a flawed distinction in order to justify disclosure without having to address the contrary weight of authority. The Court reasons unconvincingly that this distinction will discourage claims administrators from engaging in "hide the ball" tactics, which deprive participants of access to pertinent appeal documents. In fact, however, the Court's distinction will cause the opposite effect by encouraging claims administrators to avoid referencing internal guidelines when denying claims.

The Seventh Circuit's conclusion that internal guidelines have the "effect" of being plan documents when relied upon by claims administrators also is contrary to the established law and logic of §1024(b)(4). As the Court itself recognized in *Egert v. Connecticut General Life Insurance Co.*, 900 F.3d 1032, 1036 (7th Cir. 1990), internal guidelines do not constitute a part of an ERISA plan, although a claims administrator may rely upon such guidelines to interpret ERISA plans that they administer. If such guidelines conflict with the controlling terms of the ERISA plan, however, then the claims administrator is deemed to be acting arbitrarily and capriciously when relying on such guidelines. *See Swaback v. American Information Technologies Corp.*, 103 F.3d 535, 540, n.9 (7th Cir. 1996). Although a claims administrator may be unreasonably interpreting the provisions of the governing plan, however, this fact does not "effectively" turn such guidelines into plan documents. The contrary is true. Instead of informing a participant of rights under the plan, internal guidelines simply

evidence the claims administrator's erroneous exercise of discretion in denying a participant's claim, which relates to the issue of appeal.

B. The Required Disclosure Of Plan Documents Under §1024(b)(4) Is Not The Same As Disclosure For Appeal Purposes.

The Seventh Circuit's concern in this case is really targeted upon a participant's right to a full and fair review under §1133, but that is a different matter than a plan administrator's disclosure obligations under §1024(b)(4). The Court recognized this difference in *Ames*, 170 F.3d at 758-59:

> The legal question on which this dispute turns is how broadly we should construe the catch-all part of §1024(b)(4), which requires disclosure of "other instruments under which the plan is established or operated." Other Courts of Appeals have found that the use of the term "instruments" implies that the statute reaches only formal legal documents governing a plan. *See Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 652-54 (4th Cir. 1996); *Board of Trustees of the CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d 1039, 1042-45 (2nd Cir. 1997). Plaintiffs argue that this interpretation of the requirement is too narrow, and that they should have a right to all documents that provide information about a plan and its benefits. We agree with our sister circuits

> that the latter interpretation would make hash of the statutory language, which on its face refers to a specific set of documents: those under which a plan is established or operated. If it had meant to require production of all documents relevant to a plan, Congress could have said so. This is not to say, of course, that companies have a permanent privilege against disclosing other documents. It means only that the affirmative obligation to disclose materials under ERISA, punishable by penalties, extends only to a defined set of documents. If litigation comes along, then ordinary discovery rules under the management of the district court provide the limits on what must be produced.

Section 1133 requires that "specific reasons for denial be communicated to a claimant and that the claimant be afforded an opportunity for full and fair review by the administrator," This ensures that when a claimant appeals a denial of benefits, she will be able to address the determinative issues and have a fair chance to present her case. *Helpin v. W. W. Grainger, Inc.*, 962 F.2d 685, 689 (7th Cir. 1992). As the Seventh Circuit and other courts recognize, however, the statutory disclosure obligations of §1024(b)(4) are not equivalent to the obligations imposed for a full and fair review under §1133.

Recognizing the distinction between §1024(b)(4) and §1133, a consensus of courts have uniformly concluded before the present decision that internal

guidelines used by claims administrators do not constitute plan documents. The decision in *Doe v. Travelers Insurance Co.*, 167 F.3d at 60, is illustrative, and even in the present case, the Seventh Circuit acknowledged the prevailing view that internal guidelines do not constitute plan documents. The only contrary authority referenced in the Court's decision, moreover, involved a mandatory guideline upon which a claims administrator relied, and which guideline did not conflict with the terms of the controlling ERISA plan.

Where internal guidelines are not mandatory, and where they conflict with the controlling terms of a plan, they simply do not constitute plan documents that advise participants of their rights and benefits under an ERISA plan. Internal guidelines may evidence mistakes made by a claims administrator in denying a claim, but that is not within the purview of §1024(b)(4), which is intended to inform participants of rights and benefits. The penalty provision of §1132, therefore, cannot be imposed to remedy a violation of a participant's review rights under §1133. *Dade v. Sherwin-Williams*, 128 F.3d 1135, 1143 (7th Cir. 1997).

C. The Seventh Circuit's Decision Is Unworkable.

The Seventh Circuit's decision in this case attempts unconvincingly to avoid the weight of authority, including prior Seventh Circuit decisions,

by purporting to distinguish between guidelines expressly identified by a claims administrator and guidelines not expressly disclosed by a claims administrator. This is an unprecedented and untenuous distinction that is unfair to participants and unworkable for plan administrators.

The Seventh Circuit's unprecedented distinction in this case operates unfairly because the same guidelines arguably need only be disclosed to participants to whom a claims administrator made reference to the guidelines, but not to other participants.

The attempted distinction is unworkable because the disclosure obligation under §1024(b)(4) will be constantly fluctuating, claim by claim, depending upon what a claims administrator states in denying a claim. In addition, plan administrators may not actually see claim denials, yet still be subject to disclosure obligations under §1024(b)(4), even when the claims administrator erroneously relies on such guidelines in conflict with the controlling ERISA plan provisions. Section 1024(b)(4) cannot practically be implemented to compel disclosure of misinformation, just as "outdated" information does not fall into any of the categories of documents that a plan administrator must provide to participants. *Shields v. Local 705*, 188 F.3d 895, 903 (7th Cir. 1999).

D. Section 1024(b)(4) Relates To Organic Instruments.

The ERISA disclosure requirements of §1024(b)(4) relate to the organic instruments establishing and defining the terms of an ERISA plan. *See Ames*, 170 F.3d at 758. In *Ames*, the Seventh Circuit agreed with the Second and Fourth Circuits' narrow interpretation of §1024(b)(4), and in so holding, the Court rejected an interpretation requiring production of all documents relevant to a plan; if Congress intended such a broad result, it would have explicitly said so. *Id.* at 758-59. The *Ames* Court also noted that if a matter proceeded to litigation, relevant documents not falling within the disclosure provisions may still be discoverable in the ordinary course of litigation. *Id.* at 759. Section 1024(b)(4), however, does not mean that any document relating to a plan must be produced, but only formal documents that establish or govern the plan. This means only the "formal legal documents that underpin the plan." *See Doe*, 167 F.3d at 59.

Here, CIGNA's Clinical Resource Tool was not an organic document establishing or governing the operation of American Family's health benefits plan, although Department of Labor regulations do impose a separate obligation to explain or provide a copy of any internal rule, guideline, protocol, or other similar criterion relied upon by a claims administrator in making an adverse benefits determination. The obligation to either explain said criterion, or provide a copy of the criterion, however, does not arise under

§1024(b)(4). The Department of Labor regulation, instead, operates to implement the full and fair review of an adverse benefits determination under §1133.

E. DOL Regulations Implement ERISA Appeal Rights, Not §1024(b)(4).

Section 1133 requires that "specific reasons for denial be communicated to the claimant and that the claimant be afforded an opportunity for full and fair review by the administrator." To this end, regulations promulgated by the Secretary of the Department of Labor require that in cases of an adverse benefit determination by a group health plan, certain information must be provided:

> If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request . . . 29 C.F.R. §2560.503-1(g).

The Department of Labor requirements ensure that when a claimant appeals a denial of benefits, she will have a fair chance to present her case. *Helpin*, 962 F.2d at 689. In determining whether a plan complied with the §1133 requirements, moreover,

substantial compliance is sufficient. *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 775 (7th Cir. 2003).

Significantly, when adequate procedures are not provided in denying benefits, the appropriate remedy is to provide the claimant with the procedures sought in the first place. In such a case, a court does not render a determination concerning the claimant's entitlement to benefits; the matter instead is remanded to provide an opportunity for a full and fair review. *See Cook v. The New York Times Company Group Long Term Disability Plan*, 2004 U.S. Dist. LEXIS 1259 at 27 (S.D. N.Y. 2004) (a full and fair review does not require a finding in claimant's favor, but merely indicates that the claimant should receive another administrator review); *Robbins v. AETNA Life Insurance Company*, 2006 U.S. Dist. LEXIS 64394 at 12 (E.D. N.Y. 2006) (failure to provide proper notice of internal criterion requires remand for an opportunity to submit evidence supporting claimant's position).

Section 1133's notification requirements do not make internal criteria or rules part of a plan's organic or constitutive document that must be disclosed under §1024(b)(4). DOL regulations requiring notification of internal criteria do not even require a claims administrator to produce its Claims Manual. In *Palmiotti v. Metropolitan Life Insurance Company*, 2006 U.S. Dist. LEXIS 8031 (S.D. N.Y. 2006), for example, the court considered whether the notification requirements of 29 U.S.C. §1133, and implementing DOL

Regulation C.F.R. §2560.503-1(g), require that an insurer produce a copy of its Claims Manual to a Plan beneficiary. The court concluded that ERISA's notification provisions do not require disclosure of a Claims Manual, noting that the broad concept of relevance under the Federal Rules of Evidence cannot be used to construe and expand "a narrow regulatory requirement." *Id.* at 6. Finally, the court found that "the Department of Labor's explanatory statement in connection with the promulgation of the [notification] regulation makes clear that the regulation was not intended to open up to mandatory unprotected disclosure all of the internal claims processing procedures of insurance companies and other claims administrators." *Id.* at 7.

F. No Court Has Previously Recognized Internal Claims Guidelines As Constituting A Plan Document.

The Respondent claims that CIGNA's Clinical Resource Tool constitutes a plan document, despite the recognized distinction between plan documents and "internal rules, guidelines, protocols or other similar criterion relied upon in making an adverse determination." 29 C.F.R. §2560.503-1(g). The Respondent cited no prior decision recognizing internal guidelines, like CIGNA's Clinical Resource Tool, as constituting plan documents that must be produced under §1024(b)(4).

The Respondent argues, however, that internal rules, guidelines, protocols or similar criterion "should" be subject to §1024(b)(4) because such documents allegedly are relevant to the appeal of an adverse benefits determination, but that is not the applicable test, as recognized in *Ames*, 170 F.3d at 759. Plan documents constitute the formal legal instruments that underpin a plan, and this does not include internal guidelines used by a claims administrator, such as CIGNA.

Respondent's argument cannot be reconciled with the Labor Department Regulations requiring that internal guidelines be produced only in some circumstances, in order to facilitate a full and fair review on appeal. 29 C.F.R. §2560.503-1(g), requires that internal guidelines be produced as part of the appeal process – or the claims administrator may provide "a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination." Such information must be provided for a full and fair review of an adverse determination, but these internal documents do not determine the relationship between the plan and its beneficiaries, which is the type of documentation that §1024(b)(4) requires to be produced.

The distinction between internal criteria and plan documents is made clear in *Glista v. UNUM Life Insurance Company of America*, 378 F.3d 113, 115-16 (1st Cir. 2004), where the First Circuit addressed the admissibility in ERISA cases of internal guidelines and training materials that interpret certain plan

terms and that are promulgated by a plan administrator. The Court declined to adopt a hard and fast rule, concluding that such internal documents are admissible under certain conditions, but the Court analyzed the admissibility of such internal guidelines under the requirements of 29 C.F.R. §2560.503, rather than the disclosure requirements of §24(b)(4). *Id.* at 1022-25.

The obligation of CIGNA to produce its internal criterion or protocols under §2560.503 was not the same as the obligation of American Family to produce plan documents under §1024(b)(4). No case has been found, nor any case cited by the Respondent, supporting the Respondent's unprecedented proposition that American Family was obligated to produce CIGNA's Clinical Resource Tool. Section 1024(b)(4) did not impose an obligation on American Family to produce CIGNA's "internal rule, guideline, protocol or other similar criterion relied upon in making an adverse determination."

G. Internal Guidelines Do Not Govern Plan Administration.

Although a claims administrator may use internal guidelines to exercise its discretion in evaluating claims, such guidelines do not thereby become plan documents. *Egert*, 900 F.3d at 1036. *See also Filipowicz v. American Stores Benefit Plans*, 56 F.3d 807, 815, n.6 (7th Cir. 1995) (an interpretative guideline cannot limit coverage provided by the health

insurance plan, citing *Egert* for the proposition that plan provisions control where interpretative guidelines conflict with plan provisions); *Swaback v. American Information Technologies Corp.*, 103 F.3d 535, 540, n.9 (7th Cir. 1996) (holding that if fiduciaries or administrators of an ERISA plan act contrary to the plain meaning of a plan, their actions are arbitrary and capricious, including when internal guidelines contradict the plan's requirements, such as in *Egert*); and *Cozzie v. Metropolitan Life Insurance Co.*, 140 F.3d 1104, 1108 (7th Cir. 1998) (discretion to interpret a Plan does imply power to modify terms of Plan, which terms remain binding – the question is whether the interpretation is reasonable).

In *Doe*, 167 F.3d at 60, the First Circuit clearly explained that a plan administrator does not have an obligation under §1024(b)(4) to produce internal mental health guidelines used by the insurer to evaluate claims. The Court stated:

> We do not think that the mental health guidelines are one of the "other instruments," a phrase that in context refers to the formal legal documents that underpin the plan. And while the statute's "requirements" and "circumstances" language might be stretched to cover the document, this language is more reasonably directed to provisions such as those contained in the policy itself that describe the plan and legally obligate Travelers – with respect to the medical conditions covered, these provisions include the general test of medical necessity, the

> claims procedure, and like information that a beneficiary would normally consult in determining what protection was afforded by a plan.
>
> The mental health guidelines may have been used by Travelers, but Travelers was not bound to use them, nor did patients have any legal rights under them. Travelers could consult or disregard this or any other set of mental health guidelines, medical textbooks, articles, or advisors in making its judgment. To hold that Travelers' choices, from this broad and changeable menu, became part of the plan stretches the statutory language too far. The courts have understandably been cautious in reading too broadly disclosure requirements whose violation can trigger a $100.00 per day penalty, conceivably available to many plan participants and beneficiaries.

No prior precedent has been found holding that a claims administrator's internal guidelines constitute a document that must be produced under §1024(b)(4). A claims administrator may have an obligation to produce a particular guideline to ensure a fair appeal, but that obligation is not triggered by §1024(b)(4). For that reason, in *Bauman v. Mila National Health Plan*, 342 F. Supp. 2d 456, 464-65 (D. S.C. 2004), the court recognized that unyielding reliance on internal guidelines can be misplaced:

> First, nothing in the Plan document states that CIGNA's internal guidelines are binding

> upon Appellant or that the guidelines are a part of the Plan. Moreover, the guidelines fall outside the four corners of the Plan. As a result, Appellant was not on notice that her claim could be in jeopardy if she failed to strictly adhere to CIGNA's internal guidelines. Hence, CIGNA's argument [based upon the internal guidelines] must fail.

A claims administrator's use of internal guidelines is part of the process of exercising the discretion of plan interpretation. "By creating and promulgating internal guidance documents, plan administrators choose to exercise their discretion to define terms." *Glista*, 378 F.3d at 124. On the other hand, even the failure to follow internal guidelines is not evidence of bad faith by an insurer, "nor do such guidelines confer any legally cognizable right or duty on the parties." *Martin v. Polaroid Corporation*, 2004 U.S. Dist. LEXIS 9510 (D. Mass. 2004) at 5-6, quoting *Doe*, 167 F.3d at 60. Such internal guidelines, of course, cannot vary the terms of a plan being administered, or reliance on the guidelines will render a claims decision arbitrary and capricious, as the Tenth Circuit held in *McGraw v. Prudential Insurance Company*, 137 F.3d 1253, 1260 (10th Cir. 1998):

> As we read the record, Prudential has modified its definition of "medically necessary" with the additional requirement [in an internal guideline] that the treatment provide a measurable and substantial increase in functional ability for "a condition having potential for significant improvement." This

> guideline is not binding but imposes on the "condition" of MS the requirement that it has a "potential for significant improvement." However, under the terms of the plan, the medical director and subsequent Prudential fiduciaries reviewing the claim were charged with assuring only that the treatment is ordered by a doctor; is generally accepted under United States medical standards; and is neither educational, experimental, or investigational in nature. Prudential's interpretation of the plan with this criterion alters its scope and is unreasonable.

See also Vescera v. UNUM Provident Corp., 2006 U.S. Dist. LEXIS 76147 at 27 (D. Vt. 2006) (guidelines in Claims Manual do not have a legally binding effect); *Bedrick v. Travelers Insurance Co.*, 1995 U.S. Dist. LEXIS 9708 at 13 (E.D. N.C. 1995) (guidelines are not part of a plan, although they do help to ensure that the medical necessity provision is applied consistently, thus decreasing the probability of arbitrary decisions); *Giertz-Richardson v. Hartford Life and Accident Insurance Co.*, 2007 U.S. Dist. 26369 (M.D. Fla., April 10, 2007) (relevant internal guidelines and claim manual not within scope of §1024(b)(4)).

In *Ferree v. Life Insurance Company of North America*, 2006 U.S. Dist. LEXIS 48239 at 9-22 (N.D. Ga. 2006), the court also rejected a claim under §1024(b)(4) that "other documents under which a plan is established or operated" requires disclosure of internal procedures, rules, guidelines, and protocols. The court concluded that a statutory penalty for

failure to provide such internal documents was not provided for under §1024(b)(4). The court recognized, however, that the failure to provide relevant documents could result in reversal of a claims decision under ERISA's "full and fair review" provision. *Id.* at 22, n.12.

H. Plan Administrators Cannot Feasibly Know What To Produce As Plan Documents Under The Seventh Circuit's Decision.

Treating internal guidelines and information relied upon in interpreting plan language as a formal instrument that must be produced under §1024(b)(4) creates an unworkable standard for plan administrators: It is virtually impossible to know everything that must arguably be disclosed. If a claims administrator relies upon medical treatises, medical dictionaries, internal medical guidelines, etc., all of this material must be produced upon any given request – and despite the fact that a plan administrator like American Family has no way of even knowing the full spectrum of information used by a third party administrator to evaluate claims. Nor is it realistic to demand that CIGNA produce to American Family every internal standard, medical treatise, dictionary, etc., that it may rely on to evaluate claims in exercising its discretion. Information specific to particular claims must be produced as part of the full and fair review process, but that is a focused obligation, distinct from §1024(b)(4).

The Seventh Circuit implicitly misconstrues the disclosure requirement of §1024(b)(4) as mandating production of every internal document used by a claims administrator in exercising its discretion to evaluate claims. If this was a correct interpretation of the scope of documents under which a plan is operated, then realistically a plan administrator would have to produce upon request all internal documents utilized – not just those relevant to a particular claim under submission. If such internal claims handling documents constitute plan documents under §1024(b)(4), then everything must be produced applicable to any potential claim, which is beyond the reasonable scope of the ERISA disclosure requirements of §1024(b)(4), as construed by any court. The Respondent, in fact, did not cite a single case in which any court in the United States of America has held that a claims administrator's internal guidelines constitute plan documents under §1024(b)(4).

Internal claims handling guidelines, procedures and protocols are not deemed plan documents under §1024(b)(4) for a good reason. They are not binding, and a claims administrator can choose not to use the guidelines, or can choose to change the guidelines, or can choose to supplement internal guidelines. To say that such documents constitute "formal legal instruments" under which a plan is operated, therefore, misconstrues §1024(b)(4) and renders it unworkable. As the First Circuit recognized in *Doe*, 167 F.3d at 60, guidelines may be used by a claims administrator, but the administrator

> "was not bound to use them, nor did patients have any legal rights under them. Travelers could consult or disregard this or any other set of mental health guidelines, medical text books, articles, or advisers in making its judgment. To hold that Travelers' choices, from this broad and changeable menu, became part of the plan stretches the statutory language too far."

The Respondent's construction of §1024(b)(4) would render even a dictionary or medical treatise a "formal legal instrument" under which a plan is operated, if a claims administrator relies upon a dictionary or learned treatise as a basis for exercising its discretion in evaluating claims. For example, in *Osborne v. Hartford Life & Accident Insurance*, 465 F.3d 296, 299 (6th Cir. 2006), the Sixth Circuit held that a claims administrator's use of a dictionary to construe plan terms "was not arbitrary and capricious, but on the contrary, was reasonable." Reasonableness, in fact, is the test for evaluating a claims administrator's exercise of discretion under a plan, but that does not mean that every document that a claims administrator may potentially consult constitutes an instrument under which the plan is legally operated.

The documents that must be produced under §1024(b)(4), constituting formal legal instruments under which participant rights are established, are distinct from those that are used to make specific claims determinations. Guidelines, procedures, and protocols have to be produced under the fair review

procedures of ERISA, but again that is distinct from the disclosure requirements of §1024(b)(4). The disclosure requirements under the fair review procedures, moreover, are focused and manageable because they look to documents relevant to a specific appeal, whereas §1024(b)(4) imposes a requirement to produce all documents under which a plan is operated, regardless of relevance to any particular claim. That is why construing §1024(b)(4) to include every internal document used in claims handling misconstrues that statute. That is why the Seventh Circuit's decision is unprecedented.

II. A CLAIMS ADMINISTRATION AGREEMENT THAT DOES NOT DEFINE RIGHTS OR BENEFITS ALSO IS NOT A PLAN DOCUMENT UNDER §1024(b)(4).

The Seventh Circuit also concluded that the claims administration agreement between American Family and CIGNA constitutes a plan document subject to disclosure, despite the fact that it does not define the rights or benefits available to plan participants and beneficiaries. The Court concluded that claims administration agreements fall under the catch-all provision of §1024(b)(4), which requires disclosure of "other instruments under which a plan is established or operated." This is the same provision that the Court previously construed narrowly to encompass only "formal legal documents governing a plan." *Ames*, 170 F.3d at 758. Significantly, the Court also has previously held that claims administration

agreements are not plan documents within the scope of §1024(b)(4).

In *Fritcher v. Health Care Service Corp.*, 301 F.3d 811, 817 (7th Cir. 2002), the Seventh Circuit held that an administrative services agreement between an employer and a plan administrator is not a plan document defining the rights or benefits of plan participants. In the present case, the Seventh Circuit acknowledges the *Fritcher* decision, but mischaracterizes *Fritcher* as holding only that an administrative services agreement does not define participant rights or benefits, which the panel admits to be "true enough" in this case. The Court's crimped interpretation of *Fritcher*, however, incorporates a limitation that is not present in the Court's actual language in that case.

The phrase "plan documents" is a recognized term under §1024(b)(4), meaning documents necessary for participants to know their rights and obligations. This may include contracts such as claims administration agreements, but only if they include provisions necessary to apprise participants of coverage. *See Heffner v. Blue Cross and Blue Shield of Alabama*, 443 F.3d 1330, 1343 (11th Cir. 2006). In the present case, however, the CIGNA claims administration agreement undisputedly does not define the rights or benefits available to participants.

Considering the purpose of §1024(b)(4), as well as the Seventh Circuit's own prior holding in *Fritcher*, and the Court's holding in *Ames* recognizing the

narrow scope of §1024(b)(4), the present decision is needlessly inconsistent with prior decisions. The Court's rationale for change is not based upon any cognizable advantage to plan participants because the claims administration agreement in this case is irrelevant to the participant's appeal of CIGNA's denial of benefits. The panel's decision, therefore, is not only at odds with prior precedent, but without furthering any collateral objective.

The Seventh Circuit's expansive construction of the catch-all provision of §1024(b)(4) also conflicts with prior precedent limiting the duty to disclose provider agreements only if they create a financial incentive that may affect participant benefits, such as HMO provider contracts. While courts have concluded that plan administrators have a fiduciary obligation to disclose financial incentives given to providers to limit services, this disclosure duty does not arise under §1024(b)(4). In fact, some courts have refused to even recognize a fiduciary duty to disclose physician compensation plans with financial incentives precisely because ERISA does not otherwise require disclosure of such documents. *See Ehlmann v. Kaiser Foundation Health Plan of Texas*, 198 F.3d 552, 555 (5th Cir. 2000) ("It would be strange indeed if ERISA's fiduciary standards could be used to imply a duty to disclose information that ERISA's detailed disclosure provisions do not require to be disclosed.").

The Seventh Circuit's construction of §1024(b)(4) has no rational limit. Even employment agreements apparently would have to be disclosed if an employee

is hired to provide plan services, just like a contract to hire a third party claims administrator in this case. Given the purpose of §1024(b)(4) to apprise participants of their rights, such an interpretation is gratuitous and absurd.

The Seventh Circuit's construction of §1024(b)(4) in this case, so as to include documents unrelated to a participant's rights and benefits, is contrary to prior decisions of the Court and it raises uncertainty as to what else a plan administrator must predict will later be found covered by §1024(b)(4).

The claims administration agreement in this case, moreover, was not even relevant to a full and fair administrative appeal of CIGNA's denial of benefits under §2560.503. The claims administration agreement between American Family and CIGNA is not an organic document establishing and defining the terms of an ERISA plan. *See Ames*, 170 F.3d at 758-59. Respondent's own elastic construction of the term "plan documents," so as to include documents relevant to a full and fair hearing, does not implicate the claims administration agreement. Nothing in that agreement had any relevance to the issue of Respondent's appeal of CIGNA's denial of her benefits claim, let alone as to rights under the plan itself.

CONCLUSION

For all the foregoing reasons, Petitioners respectfully request that the Supreme Court grant review of this matter.

Respectfully submitted,

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In the

United States Court of Appeals

For the Seventh Circuit

No. 07-1109

SHARON MONDRY,

Plaintiff-Appellant,

v.

AMERICAN FAMILY MUTUAL INSURANCE COMPANY, *et al.*,

Defendants-Appellees.

Appeal from the United States District Court
for the Western District of Wisconsin.
No. 06 C 320 – **John C. Shabaz**, *Judge*.

ARGUED NOVEMBER 6, 2007 – DECIDED MARCH 5, 2009

Before FLAUM, KANNE, and ROVNER, *Circuit Judges*.

ROVNER, *Circuit Judge*. When Sharon Mondry sought reimbursement from her workplace insurance plan for the speech therapy her son was receiving, she was advised that the therapy was not covered by the plan because it was "educational or training" and "not restorative." For the next sixteen months, Mondry repeatedly asked both the plan and claims

administrators to supply her with the plan documents containing the language on which the claims administrator had relied in denying her claim. When the relevant documents were finally produced, it became patently clear that the provisions of these documents were inconsistent with the governing language of the insurance plan and that the claims administrator had inappropriately denied Mondry's claim for reimbursement. Once the error was exposed, Mondry prevailed. Mondry then filed suit against both the plan and claims administrators under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), contending as relevant here that they had violated a statutory obligation to produce plan documents to her and misrepresented the terms of the plan to her in violation of their fiduciary duties. The district court dismissed these claims as against the claims administrator and entered summary judgment in favor of the plan administrator. We affirm in part and reverse in part.

II.

Mondry worked for defendant American Family Mutual Insurance Company ("American Family") until September 2003. During her tenure with the company, Mondry participated in the AmeriPreferred PPO Plan (the "Plan"), a self-funded group health insurance plan that American Family offered to its employees. Mondry also enrolled her son Zev, who was born in 1999, as a beneficiary of the Plan. The

governance and terms of the plan were set forth in a Summary Plan Description ("SPD"). The SPD identified American Family as the Plan administrator but indicated that American Family had contracted with defendant Connecticut General Life Insurance Company, a subsidiary of CIGNA Corporation and an affiliate of the CIGNA HealthCare (collectively, "CIGNA"), to handle the administration of claims for services pursuant to the Plan.

On the recommendation of his pediatrician, Zev began to receive speech therapy in July 2001. Initially, that therapy was provided to Zev through Wisconsin's Birth to Three program, a partially government-funded, early-intervention program for infants and toddlers with developmental delays and disabilities. As Zev approached his third birthday (at which time he would no longer be eligible to participate in the Birth to Three program), Mondry arranged for his therapy to continue at the Communication Development Center ("CDC"). When Mondry contacted American Family's Human Resources Department to ascertain the extent to which Zev's therapy would be covered by the Plan, she was directed to the company's internal website, where a copy of the SPD was posted. After reviewing the SPD, Mondry took Zev to his first speech therapy session at CDC on January 21, 2003 and to regular sessions thereafter. CDC submitted invoices to CIGNA seeking payment for the therapy.

On June 13, 2003, CIGNA's representative, Dr. Marsh Silberstein, wrote a letter to CDC, with a copy

to Mondry, denying coverage for the speech therapy that Zev was receiving. In relevant part, the letter stated:

> Your [i.e. Mondry's] plan provides coverage for specified Covered Services which are medically necessary. After a review of the information submitted, we have determined that the requested services are not covered under the terms of your plan. This coverage decision was made based on the following:
>
> The information provided does not meet plan language for speech therapy per CIGNA guidelines. Patient has expressive language skills delay and auditory comprehension skills impairment. Speech therapy to address this delay is *educational or training.* Speech therapy is *not restorative.*
>
> *Based on CIGNA's Benefit Resource Tools Guidelines-Speech Therapy.*

R. 3 Ex. 1 (emphasis supplied).

Notably, one of the terms CIGNA used in its letter to characterize Zev's speech therapy – "not restorative" – is not found in the provisions of the Plan's SPD, and the terms "educational" and "training" are not used in the portion of the SPD dealing specifically with speech therapy. The SPD indicates that speech therapy will be covered so long as it is performed by a licensed or certified therapist and is referred by a doctor, subject to a maximum of

thirty-five visits per injury or illness unless more are deemed necessary by physician. R. 13 Ex. B at 17.[1] Moreover, as CIGNA's letter acknowledges, all claims against the Plan are subject to a general requirement, found in the SPD, that the treatment or services provided to a Plan participant be "medically necessary." By the terms of the SPD, treatment qualifies as "medically necessary" when

> services and supplies are provided by a hospital, doctor, or other licensed medical provider to treat a covered illness or injury. The treatment must be appropriate for the symptoms or diagnosis, within the standards of acceptable medical practice, the most appropriate supply or level safe for the patient, and not solely for the convenience of the patient, doctor, hospital, or other licensed professional.

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[1] The words "education" and "training" are found elsewhere in the SPD. Included among the SPD's list of expenses that are not covered are "[c]harges for custodial services, education, training, or rest cures." R. 13 Ex. B at 33. It is not clear whether the modifier "custodial" applies only to the term "services" or to all of the terms that follow. The scope of this exclusion has not been addressed by the parties on appeal. What is clear is that this exclusion does not address speech therapy in particular. As noted above, the SPD elsewhere specifically provides that speech therapy is covered so long as it is recommended by a physician and provided by an appropriate professional; no exclusion is set forth for speech therapy that may be considered "education" or "training." R. 13 Ex. B at 17. It appears that CIGNA drew the terms "educational or training" and "non-restorative" not from the SPD but from the Benefit Interpretation Resource Tool referenced below.

R. 13 Ex. B at 6. CIGNA's Benefit Interpretation Resource Tool for Speech Therapy ("BIRT"), which was cited in its letter to CDC and Mondry as the basis for CIGNA's conclusion that Zev's speech therapy was not covered by the Plan, is not part of the SPD and was not posted on American Family's internal website as a Plan document.

In response to CIGNA's letter, Mondry on June 30, 2003, wrote to both CIGNA and to American Family's benefits coordinator, Ken Dvorak, expressing her wish to appeal the adverse determination. She also requested a complete copy of the governing Plan documents, explaining, "The document I was told to pull off the American Family Intranet site is a Summary Plan Description, and is incomplete." R. 3 Ex. 3.

Mondry's first request for additional documentation of the Plan terms went unanswered. CIGNA treated her letter solely as a notice of appeal, and a CIGNA appeals processor wrote to Mondry on July 11, 2003, acknowledging her letter as such. The letter explained that CIGNA had a two-level appeals process and that her request was considered a "first level appeal," and that a physician reviewer or designee who was not involved in the original benefits determination would review that determination and resolve her appeal within thirty days. R. 3 Ex. 3. The letter said nothing about Mondry's request for a complete copy of the Plan documents. American Family did not respond to the letter.

Dr. Patricia J. Loudis reviewed the case on CIGNA's behalf and upheld the denial of coverage for Zev's speech in a letter to Mondry dated July 23, 2003. Dr. Loudis set forth the following reasons for CIGNA's conclusion that Zev's speech therapy was not medically necessary:

> • The information provided does not justify the necessity of speech therapy.
>
> • The patient has Expressive Language delays.
>
> • Notes show that the goals of therapy are to improve speech skills not fully developed.
>
> • Speech therapy is *not restorative.*
>
> • Speech therapy, which is *not restorative,* is not a covered expense per the patient's *specific plan provisions.*
>
> • *Reference CIGNA Clinical Resource tool for Speech Therapy.*

R. 3 Ex. 4 (emphasis supplied). Notwithstanding Dr. Loudis's reference to "specific plan provisions" excluding speech therapy from expenses covered by American Family's Plan, the SPD in fact reflects that speech therapy generally *is* covered, and it contains no provision specifically conditioning coverage for speech therapy on the treatment being "restorative." And as with the BIRT mentioned in the June 13 letter denying Mondry's claim, the CIGNA Clinical Resource Tool for Speech Therapy ("CRT") mentioned

by Loudis is not part of the SPD and was not posted on American Family's website as a Plan document.

On July 28, 2003, Mondry sent both CIGNA and American Family a second letter requesting "the total and complete copy of my Plan Documents." R. 3 Ex. 5. She noted that her first request for such documents had met with no response. By this time, Mondry had engaged a public interest law firm, Advocacy and Benefits Counseling for Health, Inc. ("ABC"), to represent her. She indicated in her July 28 letter that CIGNA and American Family should copy that firm on subsequent correspondence.

Mondry subsequently accepted a voluntary lay-off from American Family pursuant to a severance agreement effective September 19, 2003. R. 51 Ex. 209. Mondry elected not to exercise her right under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to purchase continued coverage under the Plan. Mondry's counsel has represented that she instead obtained insurance coverage for herself and her son Zev through Wisconsin's Badger Care, a state-sponsored program offering insurance to families with children. However, Mondry and her counsel continued their efforts to obtain reimbursement from the Plan for the speech therapy Zev had received prior to her departure from American Family and the cessation of her coverage under the AmeriPreferred Plan.

ABC attorney Jonathan Cope wrote to both CIGNA and American Family on Mondry's behalf on

September 23, 2003. Cope noted that Mondry had yet to receive a complete set of the Plan documents underlying CIGNA's adverse determination in response to her previous requests, but instead had been referred to a website. Pointing out that the failure to provide Mondry with the Plan documents could result in statutory penalties, Cope requested that the documents Mondry had requested be provided to her within thirty days. He also asked that if neither of the addressees was the Plan Administrator, that they forward his letter to the appropriate individual. R. 3 Ex. 6.

American Family responded to Cope's request in a letter dated October 16, 2003. Benefits Specialist Stacy McDaniel enclosed a copy of the SPD, and her letter stated that "This Summary Plan Description is the Plan document; we do not have a separate plan document." R. 3 Ex. 7. McDaniel added that the SPD had been available to Mondry in both paper and electronic form while she was an active employee of American Family.

Based on American Family's response, ABC attorney Bobby Peterson wrote to CIGNA's National Appeal Unit on October 30, 2003. Peterson noted that the only Plan document made available to Mondry was the SPD and that American Family had stated in its October 16 letter that there was no additional Plan document. Peterson asked CIGNA to confirm that the SPD was the legally binding Plan document. He also pointed out that Loudis's letter of July 23 referred to the CRT, which was not part of the SPD.

"We are also requesting this Clinical Resource Tool, as well as any other information used to make your decision to deny these services, be sent to the undersigned." R. 3 Ex. 8.

CIGNA responded to Peterson's inquiry with a letter it faxed to Mondry's counsel on December 10, 2003. That letter enclosed a form for Mondry to sign to authorize the release of a copy of the Level One appeal file to her counsel. The letter also stated, "In regards to the request for the Summary Plan Description (SPD)[,] you have to request this from your [previous] employer[;] per HIPAA guidelines and company policy we can[not] supply this item." R. 3 Ex. 9. The letter was silent as to Mondry's demand for a copy of the CRT.

On January 7, 2004, ABC attorney Peterson wrote another letter, this time to both CIGNA's National Appeals Unit and American Family. Peterson noted that Mondry's claim had been denied because it did not "'meet the plan language for speech therapy per CIGNA guidelines.'" R. 3 Ex. 11 (quoting June 13, 2003 Silberstein letter). Yet, neither CIGNA nor the Plan Administrator had provided to Mondry any Plan document with the language CIGNA had relied on to deny her claim; the sole document provided to Mondry, the SPD, contained no such language. "CIGNA also ignored several requests for the CIGNA Clinical Resource Tool for Speech Therapy and copies of all documents, records, and other information relevant to Ms. Mondry's appeal for benefits." *Id.* Peterson reiterated Mondry's demand

for "a copy of the legally binding plan document in effect at the time the coverage was denied for this claim, a copy of the above-mentioned Clinical Resource Tool, as well as any other information used to make the decision to deny these services." *Id.*

When CIGNA thereafter provided a packet of materials to ABC, it did not include either the CRT or any other document containing the specific Plan language that CIGNA had relied upon in denying Mondry's claim, which prompted ABC's Peterson to direct another letter to CIGNA on January 28, 2004. Peterson noted that without a copy of the specific provisions on which CIGNA's decision was based, Mondry could not prepare for a second-level appeal of that decision. Peterson argued that CIGNA's refusal to supply the specific Plan language underlying its decision was contrary to ERISA regulations, which entitle a plan participant to a copy of any internal rule, guideline, protocol, or other criterion relied upon in making an adverse benefit determination. R. 3 Ex. 12 (citing 29 C.F.R. § 2560.503-1(g)(v)(A) & (B)). He argued further that it was contrary to the SPD, which indicated that a Plan participant whose claim was denied had a right to know why it was denied and to obtain copies of any documents relating to that decision. "**For the fourth time**," the letter stated, "**we are requesting the plan language and documents used as the premise for the denial of coverage for Zev Mondry's speech therapy**." *Id.* (emphasis in original). Peterson concluded:

> To remind you of the specific information requested, we are enclosing our prior three requests for this language, as well as CIGNA's denial letter dated July 23, 2003 and two CIGNA printable reports dated June 10 and July 23, 2003. These documents refer to a CIGNA Clinical resource tool for Speech Therapy and to CIGNA's specific plan provisions. The words "Expressive Language Delays" are not found in the Summary Plan Document, and so they must exist somewhere in plan documents that have been withheld from Sharon Mondry and from ABC for Health, Inc., Sharon Mondry's authorized representative. We expect your prompt response.

Id. A copy of the letter was sent to American Family.

CIGNA sent ABC a fax on February 20, 2004, denying Mondry's request for a copy of the CRT. "[T]he CIGNA tool used is only available to internal CIGNA agencies," wrote Appeals Processor Kimberly Schmitz. R. 3 Ex. 13. Schmitz suggested that Mondry's counsel contact CIGNA's Intracorp Medical Review unit by telephone to discuss the matter. But subsequent efforts by ABC staff to resolve the matter by phone proved fruitless.

ABC turned to American Family for help in securing a copy of the CRT from CIGNA, but American Family fared no better. After ABC's Kathryn Kehoe contacted her, Rosalie Detmer, American Family's Assistant General Counsel, agreed to contact CIGNA and see if it would release a copy of

the CRT. Detmer spoke with Carl Peterson at CIGNA on April 23, 2004. Peterson informed her that CIGNA considered the CRT "propriety," that it was "too big to send anyway," and that CIGNA therefore would not produce the document to either Mondry or American Family. R. 33 ¶ 7; R. 40 Ex. B; R. 65 at 23. Peterson also advised Detmer that a "summary" had already been sent to Mondry and "that is all that is legally required." R. 40 Ex. B; R. 65 at 23.[2] So far as the record reveals, Detmer and American Family accepted Peterson's response and made no further efforts to obtain the CRT or to clarify what CIGNA had relied upon in denying Mondry's claim. Nor did Detmer contact Kehoe at ABC to report the result of her inquiry. Not until Kehoe telephoned her nearly one month later to follow up did Detmer advise her that CIGNA had refused to turn over a copy of the CRT. "I did what I agreed to do," Detmer would later testify. "I don't believe that I indicated to [Kehoe] that I would respond, simply that I would do what I said I had agreed to do." R. 65 at 28. Thereafter, ABC refocused its attention on CIGNA.

ABC itself finally obtained a copy of the CRT in July 2004. CIGNA produced the CRT after John Pendergast, who was employed with CIGNA's National Appeals Unit, spoke by telephone with ABC

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[2] It is not clear whether Peterson was referring to a summary of the CRT – in which case he was incorrect in representing that Mondry had already been provided with such a summary – or to the SPD.

legal intern Anne Berglund. According to Berglund, Pendergast told her that the CRT's provisions would be applied to Mondry's forthcoming Level Two appeal, and he agreed that disclosure of the CRT was required under ERISA. R. 3 Ex. 15. A copy of the CRT for Speech Therapy was faxed to ABC on July 2.

A review of the CRT revealed that it did not contain any of the key language that CIGNA had cited in denying Mondry's claim and sustaining the denial in her Level One appeal. The CRT did list the types of conditions for which CIGNA considered outpatient speech therapy to be "medically necessary," and it also identified the kinds of medical documentation that it would consider sufficient to support a finding of medical necessity. But the CRT did not employ any of the terminology that CIGNA had used in denying compensation to Mondry for Zev's speech therapy, including "expressive language delays," "educational or training," or "not restorative."

ABC's Berglund contacted CIGNA's Pendergast by letter on July 9, 2004, noting that the CRT lacked the language on which CIGNA had premised its denial of compensation to Mondry. ABC renewed its demand for any and all documents containing that language. R. 3 Ex. 16.

Pendergast declined ABC's request for additional documentation. On July 21, 2004, he left a voicemail for Berglund informing her that he had filed a Level Two on Mondry's behalf but that CIGNA would not be turning over any additional materials. Pendergast

indicated that the Level Two review would be based "on the SPD, the plan contract, general service agreement, and [CIGNA's] criteria." R. 3 Ex. 17.

In the ensuing weeks, ABC continued to press CIGNA to produce additional information. By telephone and by mail, ABC again asked for any and all documents on which CIGNA had relied in disposing of Mondry's claims; based on Pendergast's July 21 voice message, ABC also demanded copies of the plan contract and the general service agreement. Initially, CIGNA produced to ABC a document entitled "CIGNA Healthcare Coverage Position" which related to speech therapy. But the effective date of that document was September 15, 2004 – more than a year after Mondry's claim had been denied.

At last, ABC received by fax on October 5, 2004, a copy of the elusive BIRT – specifically, the "CIGNA Healthcare Benefit Interpretation Resource Tool for GSA 2001, Requested Service: Speech Therapy" – to which CIGNA had alluded in its June 13, 2003 letter to Mondry denying her claim for Zev's speech therapy. The BIRT was revelatory in several respects. First, the BIRT contained a definition of "medically necessary" that was significantly different from that found in the SPD. R. 40 Ex. D at 1.[3] Second, the BIRT

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[3] Whereas the SPD defines treatment and services as "medically necessary" when they are appropriate for the symptom or diagnosis, within the standards of acceptable medical practice, the most appropriate supply or level safe for the patient, and not solely for the convenience of the patient or

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cited as the governing Plan document not the AmeriPreferred SPD, but rather the CIGNA Healthcare Group Service Agreement 2001. *Id.* at 3. Third, the BIRT listed fourteen types of outpatient speech therapy that would not be covered, including the following: (1) "[s]peech therapy that is *not restorative* in nature"; (2) [s]peech therapy that is considered custodial or *educational*"; (3) [s]peech therapy that is intended to maintain speech communication"; (4) [s]peech therapy that is being used to improve speech skills that have not fully developed"; and (5) "[s]ervices, *training*, or *educational* therapy for learning disabilities, developmental delays, autism or mental retardation." *Id.* at 4 (emphasis ours).

After further correspondence and telephone communication between ABC and CIGNA, ABC concluded that CIGNA had relied upon the wrong criteria in denying Mondry's claim. ABC law clerk Molly Bushman set forth that view in a lengthy letter to Pendergast dated December 21, 2004. After

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provider, *see supra* at 5, the BIRT required that the provided services be "[n]o more than required to meet your basic health needs; and [c]onsistent with the diagnosis of the condition for which they are required; and [c]onsistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and [r]equired for purposes other than [the] comfort and convenience of the patient or his Physicians; and [r]endered in the least intensive setting that is appropriate for the delivery of health care; and [o]f demonstrated medical value." R. 40 Ex. D at 1.

summarizing much of the back and forth between ABC and CIGNA over the relevant Plan documents, Bushman noted that the BIRT's definition of medical necessity departed from the standard articulated in the SPD:

> The provisions of the BIRT are much more detailed and potentially restrictive than the provisions of the contract [i.e., the SPD]. There is absolutely no basis in the contract for the exclusion of "Expressive Language Delays" or for the requirement that the treatment be "restorative." According to your statement above [that the SPD is the controlling Plan document] and to the law, the definition of "medically necessary" in the Plan should apply to this claim, not the extraneous provisions of the BIRT. In addition, as Sharon Mondry has maintained, there is strong evidence in the medical documentation that the claim at issue was for services that were, in fact, restorative.

R. 3 Ex. 23 at 6.[4] Looking forward to Mondry's Level Two appeal, Bushman registered ABC's frustration with CIGNA's insistence that Mondry should frame her arguments based solely on the SPD rather than

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[4] This four-page letter appears to be mis-paginated. The second, third, and fourth pages of this letter are labeled pages five, six, and seven. There do not appear to be any pages missing from the copy in the record; and there is no apparent break in the text of the letter from pages one to five. To avoid confusion, however, we have cited the relevant pages of the letter as they are labeled in the record.

the BIRT or any of the additional documents that Mondry had sought from CIGNA, with or without success.

> While we agree that the BIRT is not contractually binding, it seems obvious that it was used to deny our client's claim. . . . [O]ur problem is that we do not know which standards will be applied to the medical facts. A voice mail you addressed to my colleague Anne Berglund on July 21, 2004 stated that we should argue our case based on the SPD, plan contract, general service agreement, and [CIGNA's] criteria. You recently stated to me that the SPD is the plan contract, we do not need the general service agreement, and that CIGNA's criteria (which I take to mean the [CRT] and the BIRT) are not contractually binding. Your inconsistencies do not end there. According to our phone conversation, you now want us to send our medical documents as soon as possible and schedule the hearing within two or three weeks. You also expressed that you would make every accommodation to our client's schedule. In contrast, CIGNA has refused to send us the relevant documents, neglected to answer our phone calls and letters in a timely fashion, and basically protracted this process in a manner that could in no way be characterized as accommodating.

Id. at 6-7. Apparently, there was no further document production from CIGNA following this correspondence.

When CIGNA's appeals committee heard Mondry's Level Two Appeal several months later, it agreed that her claim had been denied improperly. The hearing took place by telephone conference call on April 13, 2005; Peterson and Bushman of ABC represented Mondry at that hearing. Two days later, CIGNA sent Mondry a letter informing her that she had prevailed in her appeal:

> We are pleased to inform you that we have authorized coverage of the speech therapy services provided to Zev from January 21, 2003 through December 29, 2003. Your request has been authorized for the above listed services if you are enrolled and eligible for plan benefits on the date(s) of service. The requested services will be covered subject to Plan coverage and provisions at the time the service is rendered. We made our decision after reviewing your appeal and supporting documentation. We have made the necessary arrangements with the claims department to process the claims for payment by April 30, 2005.

R. 3 Ex. 25. The letter provided no further explanation for CIGNA's change in position.[5]

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[5] Although the record contains a copy of CIGNA's internal notes regarding Mondry's appeal, those notes shed no light on

(Continued on following page)

Ten months after the decision in Mondry's favor at the Level Two Appeal hearing, CIGNA reimbursed her for most but, according to Mondry, not all of the expenses she had incurred for Zev's speech therapy in 2003, before she left American Family's employ and opted not to accept continued COBRA coverage under American Family's Plan. Mondry asserts that she has yet to be reimbursed for $303.89 of the money she is out-of-pocket for the speech therapy Zev received in 2003.

Mondry subsequently filed suit against both American Family and CIGNA pursuant to ERISA's civil enforcement provision, 29 U.S.C. § 1132. In Count One of her complaint, Mondry alleged that in failing to timely respond to her multiple written requests for plan documents, American Family and CIGNA had violated the obligation set forth in 29 U.S.C. § 1024(b)(4) to produce such documents and were liable for fines pursuant to 29 U.S.C. § 1132(c)(1)(B). In Count Two, Mondry alleged that American Family and CIGNA breached the fiduciary

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CIGNA's rationale for deciding the appeal in Mondry's favor. The appeal notes reflect Mondry's argument that previous denials of her claim had indicated that speech therapy must be restorative in nature, which is a condition not found in the Plan language. The notes reflect Mondry's additional contention that the previous denials relied on the BIRT, a set of guidelines intended for managed care plans, which the AmeriPreferred Plan was not. But the notes contain no explanation for the appeals committee's decision, beyond noting that the decision was "[b]ased on all of the submitted information, benefit booklet and information provided during conference call." R. 51 Ex. 210.

obligations they both owed to her under 29 U.S.C. § 1104(a)(1) to administer the AmeriPreferred Plan solely in the interest of Plan participants and beneficiaries, by misrepresenting the terms of the Plan and withholding from her information that she needed to pursue her Level Two appeal. Although Mondry asserted other, non-ERISA claims against the defendants, only the ERISA claims set forth in Counts One and Two of her complaint are at issue here. Mondry has not challenged the disposition of the other claims, which were dismissed for failure to state a claim on which relief could be granted.

The district court dismissed Counts One and Two as to CIGNA and later entered summary judgment in favor of American Family as to both claims. With respect to Count One, the court held that only American Family, as the plan administrator, bore the statutory obligation to produce plan documents under section 1024(b)(4), and so CIGNA could not be held liable for any violation of that statutory provision. *Mondry v. Am. Family Mut. Ins. Co.*, 2006 WL 2787867, at *3 (W.D. Wis. Sep. 26, 2006). The court initially denied in part American Family's request for summary judgment as to Count One and instead granted partial summary judgment to Mondry on that count. The court did agree with American Family that one of the documents that Mondry had demanded, the claims administration agreement between American Family and CIGNA, did not constitute a governing plan document that American Family was statutorily obligated to produce. 2006 WL

3883601, at *8 (W.D. Wis. Nov. 21, 2006). But as to the other two documents Mondry had sought, the BIRT and CRT, the court, although it believed the question to be close, concluded that those documents qualified as plan documents whose production was required under section 1024(b)(4). *Id.*, at *9-*10. The court did not consider it to be a defense to liability that these documents were not in American Family's possession. *Id.* at *10. However, the court later reversed itself on reconsideration, relying on the letter that ABC had written to CIGNA on Mondry's behalf on December 21, 2004, in which ABC acknowledged that the BIRT was not contractually binding on CIGNA in its handling of Plan claims. The Court viewed that letter as an admission by Mondry that both the BIRT and CRT were merely advisory, internal guidelines that CIGNA was not obligated to use in evaluating benefit claims and consequently were not documents that established or governed the Plan. Consequently, American Family had no obligation to produce those documents to Mondry under section 1024(b)(4). 2006 WL 5942162, at *3 (W.D. Wis. Dec. 12, 2006). As for the breach of fiduciary duty claim set forth in Count Two, the court dismissed that claim against CIGNA because Mondry was only seeking legal relief, in the court's view, and for causes of action brought under section 1104(a)(1), section 1132(a)(3) only provides for equitable relief. 2006 WL 2787867, at *4. American Family did not seek dismissal of Count Two, but it later sought and obtained summary judgment on this claim. The court saw no proof that American Family had breached its

fiduciary duty by withholding material information from Mondry: rather, American Family had done what it could to help Mondry obtain the documents she sought from CIGNA. As for material misrepresentations, assuming that American Family had incorrectly represented to Mondry that the SPD was the only document that controlled the evaluation of her claim for benefits, there was no evidence that Mondry had relied on this representation to her detriment, because she continued to pursue her document requests. Finally, the record was devoid of proof that American Family had subjugated Mondry's interests to its own by minimizing the efforts of its staff to help Mondry locate copies of the documents that CIGNA had relied on in denying her claim. 2006 WL 3883601, at *12-*13.

II.

A. Count One: Failure to Produce Plan Documents

Pursuant to 29 U.S.C. § 1024(b)(4), the administrator of a plan has an obligation to produce to a plan participant certain documents upon her request:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary[ ] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which

> the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary [of Labor] may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

The purpose of this disclosure provision is to "ensure[] that 'the individual participant knows exactly where he stands with respect to the plan[.]'" *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 118, 109 S. Ct. 948, 958 (1989) (quoting H.R. Rep. 93-533, p.11 (1973), U.S. Code Cong. & Admin. News 1978, p. 4649). Knowing where one stands with respect to a plan includes having the information necessary to determine one's eligibility for benefits under the plan, *see Davis v. Featherstone,* 97 F.3d 734, 737 (4th Cir. 1996), to understand one's rights under the plan, *Bartling v. Fruehauf Corp.,* 29 F.3d 1062, 1070 (6th Cir. 1994), to identify the persons to whom management of plan funds has been entrusted, *Hughes Salaried Retirees Action Comm. v. Admin. of Hughes Non-Bargaining Retirement Plan,* 72 F.3d 686, 690 (9th Cir. 1995) (en banc) (quoting S. Rep. No. 93-127, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4863), and to ascertain the procedures one must follow in order to obtain benefits, *id.*

Teeth are given to this obligation by 29 U.S.C. § 1132(c)(1)(B), which renders a non-compliant

administrator liable for fines in the event he fails to timely produce requested plan documents.

> Any administrator . . . who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, . . . each violation described in subparagraph (B) with respect to any single participant or beneficiary[ ] shall be treated as a separate violation.

By regulation, the maximum permissible penalty under section 1132(c)(1) has been increased to $110 per day. 29 C.F.R. § 2575.502c-3.

Both the duty to produce and liability for the failure or refusal to produce plan documents are placed on the "administrator," and as that term is defined, it includes only American Family, not CIGNA. The term "administrator" is defined in 29 U.S.C. § 1002(16)(A) to mean:

> (i) the person specifically so designated by the terms of the instrument under which the plan is operated;
>
> (ii) if an administrator is not so designated, the plan sponsor; or
>
> (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

It is undisputed in this case that the SPD expressly designated American Family as the Plan administrator, R. 13 Ex. B at 44, thus rendering American Family the one and only "administrator," pursuant to section 1002(16)(A)(i), with the duty to produce plan documents. *Jones v. UOP,* 16 F.3d 141, 144 (7th Cir. 1994).

CIGNA's role as the claims administrator did not bring it within the reach of sections 1024(b)(4) and 1132(c)(1). Consistent with the terms of these statutory provisions, this court and others have held that liability under section 1132(c)(1) is confined to the plan administrator and have rejected the contention that other parties, including claims administrators, can be held liable for the failure to supply participants with the plan documents they seek. *Hightshue v. AIG Life Ins. Co.,* 135 F.3d 1144, 1149 (7th Cir. 1998); *Jones,* 16 F.3d at 144; *Gore v. El Paso Energy Corp. Long Term Disability Plan,* 477 F.3d 833, 843-44 (6th Cir. 2007); *Ross v. Rail Car Am. Group Disability Income Plan,* 285 F.3d 735, 743-44

(8th Cir. 2002); *Lee v. Burkhart,* 991 F.2d 1004, 1010 (2d Cir. 1993); *McKinsey v. Sentry Ins.,* 986 F.2d 401, 403-05 (10th Cir. 1993). *See also Klosterman v. Western Gen. Mgmt., Inc.,* 32 F.3d 1119, 1122 (7th Cir. 1994) (holding that liability for failing to comply with requirements of 29 U.S.C. § 1022(b) as to contents of SPD falls solely on plan administrator) (coll. cases dealing with section 1024(b)).

Mondry nonetheless suggests, incorrectly, that our decisions in *Jones* and *Rud v. Liberty Life Assurance Co. of Boston,* 438 F.3d 772, 774-75 (7th Cir. 2006), leave the door open to treating another party, including the claims administrator, as a de facto plan administrator for purposes of section 1024(b)(4). In fact, as our decision in *Jones* points out, only a minority of the circuits have shown a willingness to recognize de facto plan administrators. 16 F.3d at 145 (citing *Law v. Ernst & Young,* 956 F.2d 364, 373-74 (1st Cir. 1992); *Fisher v. Metro. Life Ins. Co.,* 895 F.2d 1073, 1077 (5th Cir. 1990); and *Rosen v. TRW, Inc.,* 979 F.2d 191 (11th Cir. 1992)). Most courts have rejected that theory. *See id.* (coll. cases). Our own decisions on the subject have never embraced the concept of a de facto plan administrator, and Mondry presents us with nothing more than a cursory argument in favor of doing so here.

What we have left the door open to is the possibility that a non-administrator may be equitably estopped to deny that it is the plan administrator. In *Jones,* we held that a retiree (Jones) was not entitled to statutory penalties from his former employer, UOP,

for its delays in responding to his requests for copies of pension plan documents. UOP was not the plan administrator but rather the plan sponsor; the plan instrument specifically designated the Signal Plan Administrative Committee as the plan administrator. We rejected the notion that UOP had assumed the statutory obligation to respond to Jones's document requests by failing to direct him and his attorneys to the Administrative Committee: "The statute is plain: if a plan administrator is designated in the plan instrument, that is who has the statutory duty to respond to requests for information in a timely fashion under threat of monetary penalty if he fails to do so." 16 F.3d at 144. We went on to acknowledge the possibility that, in the right circumstances, the doctrine of equitable estoppel might be used to impose the duty of production on someone other than the plan administrator, including a plan sponsor like UOP:

> We can imagine a case in which the plan sponsor would be estopped to deny that it was the administrator. . . . If UOP's legal department had told Jones's lawyer to forget about the Committee and direct all his document requests to the legal department, and if in reliance on this advice the lawyer had forgone an opportunity to obtain the documents from the plan administrator and Jones had suffered a harm as a result, the elements of equitable estoppel would be present. *Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 648 (7th Cir. 1993). We have no

> reason to doubt the applicability of that venerable doctrine, as a matter of federal common law, to suits for the statutory penalty. . . .

16 F.3d at 144. However, we saw no need to definitively resolve the issue, for Jones had not established the elements of equitable estoppel: Although UOP had responded to Jones's document requests, there was no proof that it had misled Jones about the identity of the plan administrator by instructing him to deal only with UOP. *Id.* at 145. *See also Rud,* 438 F.3d at 774-75 (again recognizing the possibility of using equitable estoppel to treat someone other than the official plan administrator as the plan administrator).

Here, as in *Jones,* the facts do not support CIGNA being deemed a plan administrator via equitable estoppel. There is no proof that CIGNA ever held itself out to Mondry and her counsel as the plan administrator or instructed Mondry to deal only with CIGNA to the exclusion of American Family, the actual plan administrator. Mondry's equitable estoppel theory is misfocused. She points first to CIGNA's initial decision that Zev's speech therapy was not covered under the terms of the Plan, characterizing that as a misrepresentation about the scope of plan coverage that led her not to elect continued COBRA coverage under the Plan when she left American Family's employ. But that has nothing to do with the identity of the plan administrator and the obligation to produce plan documents. More

pertinently, Mondry points to CIGNA's statements, conveyed in at least one instance through American Family, describing the CRT as a proprietary document and denying any obligation to produce either the BIRT or CRT to Mondry. Purportedly as a result of such statements, "Ms. Mondry came to believe and acted on the belief that American Family lacked either the authority or the intent to provide her with the plan documents she requested. . . . Ms. Mondry ceased communication with the designated Plan Administrator, and began directing her communications exclusively to CIGNA." Mondry Br. at 35. But the statements Mondry cites fall short of misrepresenting CIGNA's status. These statements certainly manifest CIGNA's refusal to produce the documents that Mondry wanted, and American Family's apparent acquiescence reflect its own unwillingness to do anything about CIGNA's refusal; but none of this was evidence that CIGNA was in any sense portraying itself as the plan administrator or steering Mondry away from American Family. The SPD left no doubt that American Family was the plan administrator with the statutory obligation to produce plan documents, and there is nothing in the record before us suggesting that anything CIGNA did or said led Mondry or her counsel astray on that point.

So it is American Family and American Family alone that bore the responsibility to honor Mondry's requests. The next question is whether the documents that Mondry requested are the types of

documents that section 1024(b)(4) required American Family to produce. We conclude that they are. We begin with the most straightforward of the documents that Mondry requested, the 1996 claims administration agreement between American Family and CIGNA.[6]

Section 1024(b)(4) requires the plan administrator to produce (on request) copies of "the latest updated summary[ ] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." Needless to say, the claims administration agreement is a contract, but the relevant question is whether it is a contract "under which the plan is established or operated," such that it falls within the scope of section 1024(b)(4).

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[6] It appears that Mondry first explicitly requested a copy of this agreement after John Pendergast, of CIGNA's National Appeals Unit, advised Mondry's representative that CIGNA's review of her Level Two appeal would be predicated upon, among other documents, the "general service agreement." *See supra* at 14; R. 3 Ex. 17. Thereafter, Mondry began to include that agreement in her ongoing document requests. *E.g.*, R. 3 Ex. 18. No issue is raised as to whether the "general service agreement" that Pendergast reference and the "claims administration agreement" that the parties refer to on appeal are the same or different documents, nor does either American Family or CIGNA contend that they were confused as to which agreement Mondry was seeking. It is not clear to us when Mondry finally obtained a copy of the claims administration agreement. A copy of that agreement is in the record. R. 40 Ex. A.

The claims administration agreement qualifies as such an agreement. That contract both established CIGNA as the claims administrator and identified the respective authority and obligations of American Family and CIGNA with respect to the plan: American Family bore responsibility for determining the eligibility of its employees to participate in the plan, enrolling eligible individuals in the plan, and communicating that information to CIGNA; whereas CIGNA bore responsibility for receiving benefit claims, determining whether claimants were eligible for benefits and the amount of money they were owed, disbursing payments, and providing appellate review of any adverse claims determinations. R. 40 Ex. A. The district court believed that the agreement did not qualify for production under section 1024(b)(4) because it did not "define what rights or benefits [were] available to the Plan's participants and beneficiaries." R. 45 at 19. That is true enough. *See Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 817 (7th Cir. 2002) (administrative services agreement between employer and plan administrator is not a plan document in sense that its terms may be held against plan participants and beneficiaries). But the agreement nonetheless governs the operation of the Plan in the sense that it defines the respective roles of American Family and CIGNA as the plan and claims administrators, respectively. *See Bd. of Trustees of the CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d 139, 143 (2d Cir. 1997) ("[a]greements and contracts plainly set out rights and duties"). Where the administration of a plan is

divided, as is often the case, *see, e.g., Rud,* 438 F.3d at 774, the extent of each administrator's authority is basic information that a plan participant needs to know. In that respect, we believe it qualifies as a contract under which the plan was operated, and Mondry was entitled to its production under section 1024(b)(4). *See Heffner v. Blue Cross & Blue Shield of Ala., Inc.,* 443 F.3d 1330, 1343 (11th Cir. 2006); *Michael v. Am. Int'l Group, Inc.,* 2008 WL 4279582, at *6 (E.D. Mo. Sep. 15, 2008).[7]

The other documents that Mondry requested, the BIRT and CRT, present a closer question. The obligation, if any, to produce these documents arises from section 1024(b)(4)'s catch-all reference to "other instruments under which the plan is established or operated." In *Ames v. Am. Nat'l Can Co.*, 170 F.3d 751, 758-59 (7th Cir. 1999), we rejected a broad construction of the catch-all language that would sweep within its reach all documents relevant to a plan and instead agreed with those courts which have construed the catch-all language narrowly to reach only those documents that formally govern the establishment or operation of a plan:

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[7] American Family points out that "a contract of insurance sold *to* a plan is not itself 'the plan.'" *Wallace v. Reliance Standard Life Ins. Co.,* 318 F.3d 723, 724 (7th Cir. 2003) (emphasis in original) (citing *Pegram v. Herdrich,* 530 U.S. 211, 120 S. Ct. 2143 (2000)). But that is not the type of contract that is at issue here. Connecticut General did not agree to provide insurance to American Family, but rather agreed to administer claims against the Plan on American Family's behalf.

Other courts of appeals have found that the use of the term "instruments" implies that the statute reaches only formal legal documents governing a plan. See *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 652-54 (4th Cir. 1996); *Board of Trustees of the CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d 139, 142-45 (2d Cir. 1997). Plaintiffs argue that this interpretation of the requirement is too narrow, and that they should have a right to all documents that provide information about a plan and its benefits. We agree with our sister circuits that the latter interpretation would make hash of the statutory language, which on its face refers to a specific set of documents: those under which a plan is established or operated. If it had meant to require production of all documents relevant to a plan, Congress could have said so. This is not to say, of course, that companies have a permanent privilege against disclosing other documents. It means only that the affirmative obligation to disclose materials under ERISA, punishable by penalties, extends only to a defined set of documents. If litigation comes along, then ordinary discovery rules under the management of the district court provide the limits on what must be produced. It is possible, of course, that this narrow reading of § 1024(b)(4) may create an incentive at the margins for plaintiffs to litigate rather than to rest satisfied with the internal remedies offered by a plan, so that they can find out what else

> is influencing the administrator's interpretation of a plan. Companies with a more generous view of their own obligations and self-interest may seek to counteract that incentive by disclosing more rather than less in response to employee requests.

See also Shaver v. Operating Eng'rs Local 428 Pension Trust Fund, 332 F.3d 1198, 1202 (9th Cir. 2003); *Brown v. Am. Life Holdings, Inc.,* 190 F.3d 856, 861 (8th Cir. 1999); *Doe v. Travelers Ins. Co.,* 167 F.3d 53, 60 (1st Cir. 1999); *Allinder v. Inter-City Prods. Corp. (USA),* 152 F.3d 544, 549-50 (6th Cir. 1998). Consistent with this limited construction of section 1024(b)(4), a number of courts have concluded that internal guidelines or memoranda that a claims administrator uses in deciding whether or not a claim for benefits falls within the coverage of a plan do not constitute "other instruments under which the plan is established or operated." *See Doe,* 167 F.3d at 60; *Giertz-Richardson v. Hartford Life & Accident Ins. Co.,* 2007 WL 1099094, at *2 (M.D. Fla. Apr. 10, 2007); *Morley v. Avaya Inc. Long Term Disability Plan for Salaried Employees,* 2006 WL 2226336, at *19 (D. N.J. Aug. 3, 2006); *Brucks v. Coca-Cola Co.,* 391 F. Supp. 2d 1193, 1209-12 (N.D. Ga. 2005); *Cohen v. Metro. Life Ins. Co.,* 2003 WL 1563349, at *2-*3 (S.D.N.Y. Mar. 26, 2003); *Tutolo v. Independence Blue Cross,* 1999 WL 274975, at *2 (E.D. Pa. May 5, 1999); *contra Hernandez ex rel. Hernandez v. Prudential Ins. Co. of Am.,* 2001 WL 1152835, at *4-*6 (D. Utah Mar. 28, 2001); *Teen Help, Inc. v. Operating Eng'rs Health & Welfare Trust Fund,* 1999 WL 1069756, at *2-*3

(N.D. Cal. Aug. 24, 1999); *Lee v. Dayton Power & Light Co.*, 604 F. Supp. 987, 1002 (S.D. Ohio 1985); *see also* Dep't of Labor Adv. Op. Letter 96-14a (July 31, 1996) ("it is the view of the Department of Labor that for purposes of section 104(b)(2) and 104(b)(4), any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, regardless of whether such information is contained in a document designated as the 'plan document' "). The courts holding that internal guidelines and memoranda do not constitute plan documents within the scope of section 1024(b)(4) have reasoned that however relevant such guidelines and memoranda may be to a plan beneficiary's entitlement to benefits, as internal interpretative tools they are not binding on the claims administrator and therefore do not formally govern the operation of the plan. *E.g., Doe*, 167 F.3d at 60. It is, instead, the language of the plan itself that remains dispositive of a beneficiary's rights, and of course section 1024(b)(4) expressly identifies both a plan and a summary plan description as documents to which the beneficiary is entitled.

There is also a separate statutory provision that may, in conjunction with regulations that the Secretary of Labor has promulgated, entitle a plan beneficiary to copies of the internal guidelines and other documents on which a claims administrator has

relied in denying her claim for benefits. 29 U.S.C. § 1133 provides that "[i]n accordance with regulations of the Secretary, every employee benefit plan shall – . . . (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." The Secretary's regulations in turn state that a plan will not be deemed to have afforded a claimant "full and fair review" unless, among other things, the claimant was provided "reasonable access to, and copies of, all documents, records, and other information *relevant to the claimant's claim for benefits.*" 29 C.F.R. § 2560.503-1(h)(2)(iii) (emphasis ours). A document is deemed "relevant" if it "[w]as relied upon in making the benefit determination" or, in the case of a group health plan, the document "constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination." § 2560.503-1(m)(8)(i) and (iv). Many items that do not qualify as documents that govern the establishment or operation of a plan for purposes of section 1024(b)(4) may qualify as documents that are relevant to a plan participant's claim for benefits for purposes of section 1133(2) and the Secretary's regulations. *Doe,* 167 F.3d at 60-61. Thus, a participant who is denied access to internal guidelines that relate to her unsuccessful claim for benefits may be able to show that she was denied full and fair review of the denial by the claims

administrator. *Id.*; *Brucks,* 391 F. Supp. 2d at 1212 n.18. *Cf. Wilczynski v. Lumbermens Mut. Cas. Co.,* 93 F.3d 397, 402-03, 406-07 (7th Cir. 1996) (although plaintiff's contention that she was denied a copy of her disability claim file failed to state a claim for statutory penalties under section 1132(c), her allegation that without the claim file she could not identify "pertinent documents" and formulate a meaningful appeal was sufficient to state viable claim that insurance company denied her meaningful access to final administrative review).

Mondry did not seek relief under section 1133(2), but it is no mystery why she did not. Mondry ultimately obtained copies of the BIRT and CRT, and it was in large part the production of those documents that enabled her to show that CIGNA had improperly denied her claim for the speech therapy Zev had received. Mondry, in fact, prevailed at her Level Two appeal, convincing CIGNA to reverse its position and grant her claim. Having succeeded in her appeal, Mondry was in no position to argue that CIGNA denied her the full and fair review to which she was entitled under section 1133(2). The harm that she suffered was not the denial of full and fair review, but rather the lengthy delay in the production of documents that were key to her success in that review. That is why she contends that she was entitled to the timely production of the BIRT and CRT pursuant to section 1024(b)(4) and is now entitled to penalties pursuant to section 1132(c)(1)(B) for the defendants' failure to produce these

documents within thirty days of her written demand for these documents.

We may assume, without deciding, that had CIGNA privately relied on the CRT and BIRT as reference materials to guide its interpretation and application of the plan language, these documents would not have come within the scope of section 1024(b)(4). In that circumstance, it would not be possible to characterize the CRT and BIRT as documents that formally established or governed the operation of the plan. *See Ames,* 170 F.3d at 758-59. The language of the plan itself would have remained dispositive of one's entitlement to benefits, and that language would be all that a plan participant would require in order to know her rights and to effectively appeal any adverse benefits determination. Had Mondry been denied copies of the BIRT and CRT and had she lost her Level Two appeal, she might have had an argument that her inability to see the interpretative tools that CIGNA had relied on in applying the plan language denied her the right to full and fair review accorded to her by section 1133(2). *See* 29 C.F.R. § 2560.503-1(h)(2)(iii); *cf. Wilczynski,* 93 F.3d at 402-03. She might also be entitled to the production of the BIRT and CRT in discovery in a lawsuit, as we suggested in *Ames.* 170 F.3d at 759.

But CIGNA did not treat the BIRT and CRT as private guidelines that merely illuminated plan language – anything but. CIGNA expressly cited both documents as the basis for its decision to deny

Mondry's claim for benefits and invited Mondry's reference to them. In its first letter to Mondry (dated June 13, 2003) denying her claim, CIGNA spelled out its reasons for concluding that Zev's speech therapy was not medically necessary – noting that his therapy was "not restorative" but rather "educational or training" – and concluded the rationale with the following notation: "Based on CIGNA's Benefit Resources Tools Guidelines – Speech Therapy." R. 3 Ex. 1. The following month, in CIGNA's July 23, 2003 letter denying Mondry's first-level appeal, Dr. Loudis reiterated CIGNA's conclusion that "[s]peech therapy, which is not restorative, is not a covered expense per the patient's specific plan provisions." R. 3 Ex. 4. Rather than directing Mondry to the provisions of the SPD, Loudis's letter advised Mondry to "[r]eference CIGNA['s] Clinical Resource tool for Speech Therapy." *Id.* Thus, in its correspondence with Mondry denying her claim for benefits and then affirming that denial, CIGNA treated the BIRT and CRT as authoritative sources, citing them expressly as the bases for its decisions and overtly inviting Mondry to consult them. Moreover, as the letters themselves suggested and a review of the BIRT later confirmed, CIGNA was citing language from the BIRT that was nowhere to be found in the SPD's definition of what is "medically necessary" and which, in fact, constituted a substantive departure from the Plan language. In particular, nothing in the SPD suggests that therapy must be "restorative" in order to qualify as "medically necessary." In short, CIGNA had been relying on the BIRT and CRT as the equivalent of plan language,

treating the former documents as if they were dispositive and citing them to Mondry as such. Having expressly relied on the BIRT and CRT as the bases for its decision to deny Mondry's claim for benefits, CIGNA gave those guidelines the status of documents that govern the operation of a plan, and their production to Mondry thus became mandatory under section 1024(b)(4).

The fact that neither document was actually binding on CIGNA – indeed, that CIGNA had relied upon them improperly – is beside the point. What is relevant is that CIGNA expressly relied on them, and language from one of them, as dispositive in denying her claim. That is what entitled Mondry to the production of these documents as plan documents. It would be no different if CIGNA had instead cited an old version of the plan in denying Mondry's claim. Normally, a plan participant would not be entitled to outdated plan documents under section 1024(b)(4). *See Shields v. Local 705, Int'l Bhd. of Teamsters Pension Plan,* 188 F.3d 895, 903 (7th Cir. 1999). But were a claims administrator to expressly rely on a superseded version of the plan, it would be treating that version (albeit in error) as the document that governs the operation of the plan; and for that reason the participant would be entitled to its production. As we noted at the outset of our discussion, the purpose of section 1024(b)(4)'s disclosure provision is to enable a plan participant to understand his rights under the plan, including his eligibility for benefits. *Supra* at 23. When a claims administrator

mistakenly relies on an expired version of the plan document, a set of internal guidelines, or any other extraneous document in lieu of the governing plan language and, indeed, cites the language of that document as controlling to the participant, then the participant must have access to that document in order to understand what the claims administrator is doing and to effectively assert his rights under the plan. It does not strike us as a coincidence that CIGNA's decision to reverse itself and grant Mondry's claim for benefits came *after* CIGNA finally produced the BIRT and CRT to her counsel. One may plausibly infer from the record that it was the production of those documents that enabled Mondry and her counsel to expose CIGNA's error and convince CIGNA that she was entitled to benefits under the governing plan language.

For the same reason, the fact that Mondry's representative agreed, in her December 21, 2004 letter to CIGNA, that the BIRT was not contractually binding on CIGNA, is a red herring. Recall that this is what the district court ultimately relied on to reject Mondry's claim. 2006 WL 5942162, at *3. We may set aside without comment any question as to whether Mondry may be bound in this suit by a letter written prior to the litigation by a law clerk. Having by that time seen the BIRT and CRT, Mondry's representative was merely correctly arguing that the BIRT contained language that was not found in the Plan – i.e., the SPD – itself and that, in fact, was inconsistent with the SPD, and yet CIGNA appeared

to have relied on the BIRT rather than the governing Plan language in denying her claim. R. 3 Ex. 23 at 6-7. Indeed, in the same sentence that she agreed with the proposition that the BIRT was not binding, Mondry's representative also remarked that "it seems obvious that [the BIRT] was used to deny our client's claim. . . ." *Id.* at 6. This was wholly consistent with the legal theory that Mondry has espoused in this suit: that although neither the CRT nor the BIRT was a binding plan document, because CIGNA treated them as such, Mondry was entitled to their production under section 1024(b)(4).

Our holding is a narrow one. We are not saying that simply because a claims administrator relies on a set of internal guidelines, rightly or wrongly, in denying a claim for benefits, those documents become subject to mandatory production under section 1024(b)(4); that is an issue we need not and do not reach. But when a claims administrator expressly cites an internal document and treats that document as the equivalent of plan language in ruling on a participant's entitlement to benefits, the administrator renders that document one that in effect governs the operation of the plan for purposes of section 1024(b)(4), and production of that document is required. To hold otherwise would, in our view, allow a claims administrator to "hide the ball" from the participant, depriving her of access to the very documents that the claims administrator is saying are dispositive of her claim.

A final wrinkle here is that CIGNA rather than American Family had possession of the BIRT and CRT, and yet CIGNA was not the plan administrator with the statutory obligation to produce plan documents. American Family argues that this is a reason to relieve it of liability, particularly in view of the fact that at Mondry's urging, one of its attorneys contacted CIGNA in April 2004 in an effort to obtain a copy of the CRT but was told by CIGNA that the CRT was a proprietary document that CIGNA was unwilling to produce. At that point, American Family argues, it had done all that it could do for Mondry and bore no culpability for CIGNA's continued delays in producing the CRT and other documents to her. Section 1132(c)(1)(B) itself indicates that a plan administrator will not be liable for penalties where its failure or refusal to produce plan documents "results from matters reasonably beyond the control of the administrator."

In the normal course of events, the plan administrator will possess all of the documents whose production is required by section 1024(b)(4) even where responsibility for administration of the plan is divided, as it was here. As we discussed earlier, the universe of documents that qualify as ones "under which the plan is established or operated" for purposes of this statutory provision is small and is limited to those documents that formally, i.e., legally, govern the establishment or operation of the plan. The plan administrator will necessarily have those documents even when responsibility for handling

claims for benefits has been assigned to a different party.

A problem will arise, as it has here, when the claims administrator mistakenly treats its own internal guidelines and checklists as binding, placing them on par with (or even displacing) the plan itself. When the claims administrator cites such internal documents as controlling, those documents will become subject to production pursuant to section 1024(b)(4), for the reasons we have discussed. And the duty to produce these documents will still belong to the plan administrator, just as it does with respect to other plan documents. That may pose a bit of a challenge for the plan administrator when the documents in question are within the exclusive possession of the claims administrator.

Any dilemma this may have posed for American Family did not excuse its statutory obligation to Mondry, however. It was American Family, of course, that decided to engage someone else as claims administrator, that chose CIGNA, and that gave CIGNA the authority to handle claims on its behalf. Section 2 of the contract between the two parties expressly identified CIGNA as American Family's agent for purposes of claims administration. R.40 Ex. A at 1. Moreover, once American Family was placed on notice that CIGNA was expressly relying on language not found in the plan itself to deny Mondry's claim and that Mondry was demanding copies of the documents containing that language, American Family had an obligation to obtain those

documents from CIGNA and to produce them to Mondry in compliance with its duty as the plan administrator. True, on the one occasion that American Family's attorney discussed Mondry's request for a copy of the CRT with CIGNA's Carl Peterson, Peterson claimed that the CRT was proprietary and, in any event, too voluminous to produce. Obviously, however, CIGNA did not stick to its position: CIGNA ultimately produced both the CRT, which turned out not to be voluminous at all, and later the BIRT to Mondry voluntarily. The production likely would have occurred much sooner had American Family itself insisted that CIGNA turn over the documents. But even if CIGNA had not changed its mind, we are not persuaded that its refusal to produce these documents would have relieved American Family of its statutory duty to Mondry.

If the contract between American Family and CIGNA did not give American Family the right to insist on the production of internal documents such as the BIRT and CRT, this was certainly a right that American Family could have bargained for. A review of the 1996 service agreement between American Family and CIGNA suggests that American Family indeed may have had the contractual right to insist on being given copies of documents such as the CRT and BIRT, whether pursuant to section 6(a) of the agreement, which assigned to American Family the ownership of "[a]ll documents relating to the payment of claims," or section 6(d), which obliged CIGNA to

make available by audit its "files, books, procedures and records pertaining to the Plan or the services provided by [CIGNA] under this Agreement." R. 40 Ex. A at 4-5. We say that American Family *may* have had such a right because the parties have not briefed the issue, and it is not, in our view, one that we need to resolve – although for what it is worth, we note that CIGNA's counsel at oral argument represented that American Family did have the right under the agreement to demand these documents from CIGNA. What matters, in our view, is that American Family contracted with CIGNA to handle claims administration as its agent, and if American Family did not include in the contract a provision entitling it to copies of any documents that might be covered by section 1024(b)(4), it certainly could have done so. Access to such documents thus was not a matter "reasonably beyond the control" of American Family as the plan administrator. *See* § 1132(c)(1)(B).

Mondry was entitled to copies of the service agreement between American Family and CIGNA, the BIRT, and the CRT, and American Family as the plan administrator is liable for its failure to produce these documents to Mondry within thirty days of her written requests for them. We have no doubt that had these documents (in particular, the BIRT and CRT) been produced to her in a timely fashion, CIGNA's apparent negligence in denying Mondry's claim for reimbursement for her son's speech therapy would have been rectified much sooner than it was. Mondry is entitled to statutory penalties for the late

production. Although we affirm dismissal of Count One of Mondry's complaint as against CIGNA, because CIGNA was not the plan administrator, we shall reverse the district court's entry of summary judgment in favor of American Family and remand with directions to enter summary judgment in favor of Mondry and against American Family on Count One. The determination of the appropriate penalty amount is a matter within the district court's discretion. § 1132(c)(1); *see Ames,* 170 F.3d at 759-60. We shall remand the case to the district court for a determination as to the appropriate amount of the penalty.

B. Count Two: Breach of Fiduciary Duty

In Count Two of her complaint, Mondry alleges that both CIGNA and American Family violated the duties they owed to her as fiduciaries under 29 U.S.C. § 1104(a)(1). *See Kannapien v. Quaker Oats Co.,* 507 F.3d 629, 639 (7th Cir. 2007) (outlining elements of claim for breach of fiduciary duty), *cert. denied,* 129 S. Ct. 62 (2008). Neither defendant disputes that it qualifies as a fiduciary under ERISA. *See* 29 U.S.C. § 1002(21)(A)(i) & (iii) (defining fiduciary to include any person with discretionary authority in management of plan or its assets or discretionary responsibility in administration of plan); *see also, e.g., Moore v. LaFayette Life Ins. Co.,* 458 F.3d 416, 438 (6th Cir. 2006) (claims administrator is fiduciary when it has authority to grant or deny benefit claims); *Jenkins v. Yager,* 444 F.3d 916, 924 (7th Cir. 2006) (deeming plan

administrator a fiduciary). Mondry asserts that CIGNA breached its fiduciary obligations by misrepresenting the terms of the plan and failing to timely disclose material information necessary for her to pursue her Level Two appeal for benefits. Pursuant to 29 U.S.C. § 1132(a)(3), she seeks to hold CIGNA liable for $303.89 in medical expenses for which she alleges CIGNA has yet to reimburse her, additional medical expenses that she incurred because she declined COBRA coverage based on CIGNA's alleged misrepresentations, and the lost time value of funds that she spent on Zev's speech therapy before she was finally reimbursed following her successful Level Two appeal. As to American Family, Mondry alleges that her former employer failed to produce the information that she needed to prosecute her appeal of the original decision to deny her claim for benefits (again, the BIRT and CRT), misrepresented to her that the one and only Plan document was the SPD, and subjugated her interests to its own by taking a hands-off role in clarifying which documents governed her claim for benefits and in helping her to obtain those documents from CIGNA. Mondry contends that, like CIGNA, American Family is liable for the lost time value of the funds she used to pay for Zev's speech therapy until she prevailed in her Level Two appeal as well as the expenses Mondry incurred as a result of her decision to decline COBRA coverage. As we have noted, the district court dismissed the breach of fiduciary duty claim as to CIGNA on the ground that the complaint did not seek equitable relief. The court later granted summary judgment in favor of

American Family on this claim because Mondry had not established that American Family made a misleading representation to her, that she had relied on such a misrepresentation to her detriment, or that American Family had subjugated Mondry's interests to its own.

The statutory provision pursuant to which Mondry seeks relief authorizes only a limited range of remedies, raising a threshold question as to whether the relief she demands is authorized. Section 1132(a)(3) provides:

> A civil action may be brought ... by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, (B) to obtain other appropriate equitable relief (i) to redress such violations, or (ii) to enforce any provisions of this subchapter or the terms of this plan.

The Supreme Court's decision in *Varity Corp. v. Howe,* 516 U.S. 489, 507-15, 116 S. Ct. 1065, 1075-79 (1996), confirms that section 1132(a)(3) is an appropriate vehicle for remedying a breach of the fiduciary obligations owed to plan participants. But Mondry is seeking monetary rather than injunctive relief, and the former can be justified only if it falls within the scope of the "other appropriate equitable relief" authorized by the statute. The Court in *Mertens v. Hewitt Assocs.,* 508 U.S. 248, 113 S. Ct. 2063 (1993), rejected an expansive construction of "equitable relief" that might have included legal remedies, and

instead construed the term to include only "those categories of relief that were *typically* available in equity. . . ." *Id.* at 256, 113 S. Ct. at 2069 (emphasis in original). The Court's subsequent decision in *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204, 210, 122 S. Ct. 708, 712-13 (2002), reaffirmed that the "equitable relief" authorized by section 1132(a)(3) will normally not include monetary relief, even when the plaintiff asserts that an ERISA plan entitles him to the money he seeks:

> Here, petitioners seek, in essence, to impose personal liability on respondents for a contractual obligation to pay money – relief that was not typically available in equity. "A claim for money due and owing under a contract is 'quintessentially an action at law.'" *Wal-Mart Stores, Inc. v. Wells,* 213 F.3d 398, 401 (C.A.7 2000) (Posner, J.). "Almost invariably . . . suits seeking (whether by judgment, injunction or declaration) to compel the defendant to pay a sum of money to the plaintiff are suits for 'money damages,' as that phrase has traditionally been applied, since they seek no more than compensation for loss resulting from the defendant's breach of legal duty." *Bowen v. Massachusetts,* 487 U.S. 879, 918-919, 108 S. Ct. 2722, 101 L.Ed.2d 749 (1988) (SCALIA, J., dissenting). And "[m]oney damages are, of course, the classic form of *legal* relief." *Mertens, supra,* at 255, 113 S. Ct. 2063.

(Emphasis in original.) *Cf. Sereboff v. Mid Atlantic Med. Servs.*, 547 U.S. 356, 126 S. Ct. 1869 (2006) (suit by insurer seeking reimbursement pursuant to plan provision from identifiable funds within defendants' possession was a suit for "appropriate equitable relief" within scope of section 1132(a)(3)).

As *Knudson* makes clear, Mondry's claim for the $303.89 that she claims CIGNA has yet to pay her as reimbursement for Zev's speech therapy is a form of legal relief that section 1132(a)(3) does not authorize. It is a demand for money to which Mondry believes the terms of the Plan entitle her. As such it is relief that Mondry could have sought under section 1132(a)(1)(B), which expressly authorizes a suit by a plan participant "to recover benefits due to him under the terms of the plan[.]" *See, e.g., Magin v. Monsanto Co.*, 420 F.3d 679, 687-88 (7th Cir. 2005) (suit for benefits due under plan is not suit for equitable relief). But Mondry has never invoked that provision as support for her claim. *Varity* observes that section 1132(a)(3) authorizes only "appropriate" equitable relief, 516 U.S. at 515, 116 S. Ct. at 1079, and adds that where relief is available to a plan participant under other provisions of the statute, relief may not be warranted under section 1132(a)(3):

> We should expect that courts, in fashioning "appropriate" equitable relief, will keep in mind the "special nature and purpose of employee benefit plans," and will respect the "policy choices reflected in the inclusion of certain remedies and the exclusion of

> others." *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. [41], at 54, 107 S. Ct. [1549], at 1556 [(1987)]. See also [*Massachusetts Mut. Life Ins. Co. v.*] *Russell,* 473 U.S. [134], at 147, 105 S. Ct. [3085], at 3092-3093 [(1985)]; *Mertens,* 508 U.S., at 263-264, 113 S. Ct., at 2072. Thus, we should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate." Cf. *Russell, supra,* at 144, 105 S. Ct., at 3091.

516 U.S. at 515, 116 S. Ct. at 1079. Consistent with *Varity*'s admonition, a majority of the circuits are of the view that if relief is available to a plan participant under subsection (a)(1)(B), then that relief is *un*available under subsection (a)(3). *See Korotynska v. Metro. Life Ins. Co.,* 474 F.3d 101, 106 (4th Cir. 2006) (coll. cases). Although we have not had occasion to consider that question, Mondry has given us no reason to depart from the holdings of those circuits.

Nor has Mondry shown that she is entitled to compensation for the additional medical expenses she was forced to pay as a result of her decision not to continue participating in the Plan under COBRA when she terminated her employment with American Family. Mondry's contention is that when CIGNA initially denied her claim for Zev's speech therapy, it represented to her, falsely, that the therapy was outside the scope of her coverage; thus, when the time came for her to decide whether to elect COBRA

coverage, she concluded in reliance on that misrepresentation that there was no point in remaining with the Plan. She maintains that American Family itself played a supporting role in the misrepresentation by not taking meaningful steps to help her obtain from CIGNA the documents that she needed to expose the error in CIGNA's denial of her claim. But what Mondry relied upon in electing to forgo continued participation in the Plan under COBRA was CIGNA's initial, erroneous decision to deny her claim. Yet, Mondry herself realized that CIGNA's decision was not final: She had appeal rights, she exercised those rights, and she ultimately prevailed. It takes more than a mistaken decision by the claims administrator to establish a breach of fiduciary duty. *Schoonmaker v. Employee Sav. Plan of Amoco Corp. & Participating Cos.*, 987 F.2d 410, 414-15 (7th Cir. 1993) (citing *Lister v. Stark*, 11 Employee Benefits Cas. (BNA) 1611, 1617 (N.D. Ill. Aug. 1, 1989), *rev'd in part on other grounds*, 942 F.2d 1183 (7th Cir. 1991)). Nothing that CIGNA or American Family allegedly did or said coerced or deceived Mondry into waiving her COBRA rights and opting out of the AmeriPreferred Plan during the period of time when she was appealing CIGNA's adverse benefit determination.

However, we do think that Mondry has a viable claim against American Family for the lost time value of the money she was forced to expend on Zev's speech therapy until at last she obtained copies of the BIRT and CRT and was able to prevail in her Level Two

appeal. Mondry could not have sought this form of relief under section 1132(a)(1)(B), for absent a provision in the plan that grants her the right to interest on past-due benefits (and the AmeriPreferred Plan contains no such provision), restitution of this sort is considered an extra-contractual remedy that is beyond the scope of that section. *See May Dep't Stores Co. v. Fed. Ins. Co.*, 305 F.3d 597, 603 (7th Cir. 2002); *Harsch v. Eisenberg*, 956 F.2d 651, 654-56 (7th Cir. 1992); *see also Harzewski v. Guidant Corp.*, 489 F.3d 799, 804 (7th Cir. 2007). Of course, Mondry has already established American Family's liability for statutory penalties under section 1132(c)(1) for its failure to produce Plan documents to her under section 1024(b)(4), but the purpose of those penalties is to induce the plan administrator to comply with the statutory mandate rather than to compensate the plan participant for any injury she suffered as a result of non-compliance. *See Winchester v. Pension Comm. of Michael Reese Health Plan, Inc. Pension Plan*, 942 F.2d 1190, 1193 (7th Cir. 1991); *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 659 (4th Cir. 1996) (coll. cases); *see also Bartling v. Fruehauf Corp., supra*, 29 F.3d at 1068. This is not to say that the harm Mondry suffered due to the lengthy delay in obtaining the documents she sought is irrelevant to the assessment of statutory penalties; on the contrary, it is a material consideration, although not a prerequisite. *See Harsch*, 956 F.2d at 662; *see also Romero v. SmithKline Beecham*, 309 F.3d 113, 120 (3d Cir. 2002) (Alito, J.) ("Other circuits have studied the role of prejudice or damages in the inquiry and have

concluded that although they are often factors, neither is a *sine qua non* to a valid claim under section 502(c)(1).") (coll. cases); *Moothart v. Bell,* 21 F.3d 1499, 1506 (10th Cir. 1994) (same). But it is to say that the penalties imposed will not necessarily compensate her for her loss. Consequently, the door remains open to Mondry's request for relief under section 1132(a)(3), so long as what she seeks may be considered equitable relief.

Restitution amounts to a legal remedy in some circumstances and an equitable remedy in others. *See S.E.C. v. Lipson,* 278 F.3d 656, 663 (7th Cir. 2002). "[I]t is a legal remedy when sought in a case at law (for example, a suit for breach of contract) and an equitable remedy when sought in an equity case. . . . [H]owever, restitution is equitable when it is sought by a person complaining of a breach of trust. . . ." *Clair v. Harris Trust & Sav. Bank,* 190 F.3d 495, 498 (7th Cir. 1999) (citing *Health Cost Controls of Ill., Inc. v. Washington,* 187 F.3d 703, 710 (7th Cir. 1999)); *see also Bowerman v. Wal-Mart Stores, Inc.,* 226 F.3d 574, 592 (7th Cir. 2000); *Parke v. First Reliance Standard Life Ins. Co.,* 368 F.3d 999, 1006-09 (8th Cir. 2004). Mondry, like the plaintiffs in *Clair,* is complaining of a breach of trust. American Family was a fiduciary, and Mondry charges that it breached its fiduciary obligation to her by failing to help her timely obtain the documents to which she was entitled under ERISA and that she needed to establish her right to Plan benefits. *See generally Eddy v. Colonial Life Ins. Co. of Am.,* 919 F.2d 747, 750 (D.C. Cir. 1990) ("The

duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA."). Because the AmeriPreferred Plan was self-funded, American Family arguably benefitted from the delay that Mondry experienced in obtaining those documents and reversing CIGNA's erroneous denial of her claim for benefits: It had the interest-free use of money that should have been paid to Mondry much sooner than it was. Restitution would thus force American Family to disgorge the gain it enjoyed from the delay that its breach of trust helped to bring about. *See May Dep't Stores,* 305 F.3d at 603; *Lipson,* 278 F.3d at 663; *Clair,* 190 F.3d at 498.

This assumes that American Family in some way breached its fiduciary obligations to Mondry. ERISA requires a fiduciary to

> discharge his duties with respect to a plan solely in the interest of participants and beneficiaries and –
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence then prevailing that a prudent man acting in a like capacity and familiar with such matters

> would use in the conduct of an enterprise of a like character and with like aims. . . .

29 U.S.C. § 1104(a)(1). Subsection (A) of this provision imposes a duty of loyalty upon plan administrators, *Frahm v. Equitable Life Assurance Soc. of U.S.*, 137 F.3d 955, 960 (7th Cir. 1998), akin to that of a trustee under common law, *Jenkins v. Yager, supra,* 444 F.3d at 924 (quoting *Ameritech Benefit Plan Comm. v. Commc'n Workers of Am.*, 220 F.3d 814, 825 (7th Cir. 2000)); *see also Varity,* 516 U.S. at 506, 116 S. Ct. at 1074-75, and subsection (B) creates a duty of care in executing that duty, *Frahm,* 137 F.3d at 960.[8] At common law, a trustee is obliged to provide beneficiaries, at their request, "'complete and accurate information as to the nature and amount of the trust property,' and also 'such information as is reasonably necessary to enable [them] to enforce [their] rights under the trust or to prevent or redress a breach of trust.'" *Faircloth v. Lundy Packing Co., supra,* 91 F.3d at 656 (quoting Restatement (Second) of Trusts § 173 & cmt. c. (1959)); *see also Eddy,* 919 F.2d at 750. In the ERISA context, our cases have recognized the fiduciary's duty not to "'mislead plan participants or misrepresent the terms or administration of a plan,'" *Vallone v. CNA Fin. Corp.*, 375

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[8] A fiduciary who breaches his obligations to a plan participant or beneficiary is "subject to such . . . equitable or remedial relief as the court may deem appropriate. . . ." 29 U.S.C. § 1109(a).

F.3d 623, 640 (7th Cir. 2004) (quoting *Anweiler v. Am. Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir. 1993)), although we have also cautioned that not all mistakes or omissions in conveying information about a plan amount to a breach of fiduciary duty, *Frahm*, 137 F.3d at 960. *See also Tegtmeier v. Midwest Operating Eng'rs Pension Trust Fund*, 390 F.3d 1040, 1047 (7th Cir. 2004); *Vallone*, 375 F.3d at 640-41; *cf. Varity*, 516 U.S. at 506, 116 S. Ct. at 1074-75 (reserving question as to whether ERISA fiduciaries have duty to provide truthful information to plan participants, whether on own initiative or in response to participants' inquiries, but agreeing that fiduciaries may not deliberately deceive plan participants and beneficiaries).

Our colleagues in the Fourth Circuit have also looked to the specific disclosure requirements that Congress set forth in 29 U.S.C. §§ 1022(a) and 1024(b) to inform the scope of the fiduciary's duty to communicate accurate information about the plan to plan beneficiaries. *See Rodriguez v. MEBA Pension Trust*, 872 F.2d 69, 73-74 (4th Cir. 1989) (Wilkinson, J.). Although that court has declined to impose on a plan fiduciary a duty to disclose more information than ERISA's notice provisions require, *Faircloth*, 91 F.3d at 656-58, it has concluded that when a fiduciary fails to make the types of disclosures expressly required by the statute, it has breached its fiduciary obligation to the plan beneficiary, *Rodriguez*, 872 F.2d at 73-74; *see also Eddy*, 919 F.2d at 750 (noting that the fundamental common-law duty of trustee to

communicate material information to beneficiary informs many of ERISA's disclosure provisions, including those found in §§ 1022(a) and 1024(b)(4)). We discern no reason to part ways with our sister circuit on this point.

Against this legal backdrop, Mondry has presented evidence from which a factfinder could determine that American Family breached its fiduciary duty to her. Under the express terms of section 1024(b)(4), Mondry was entitled to copies of plan documents, and as we have held, those documents included the BIRT and CRT that the Plan's claims administrator had cited to Mondry as dispositive of her claim for benefits. Mondry could not effectively challenge CIGNA's decision to deny her claim based on these documents without knowing their contents. American Family had notice of the documents Mondry was seeking, her reasons for seeking these documents, and the apparent centrality of those documents to CIGNA's decisionmaking based on the correspondence that was directed to American Family, the telephonic contacts between American Family and Mondry's representatives, and the correspondence directed to CIGNA on which American Family was copied. In one instance, an in-house attorney for American Family contacted CIGNA on Mondry's behalf to request a copy of the CRT; but American Family dropped its efforts after CIGNA's representative claimed that the CRT was proprietary and "too big to send anyway." Yet a factfinder might conclude that American Family's heart was not in the

effort, for its attorney not only accepted CIGNA's refusal without question, but did not even bother picking up the telephone to advise Mondry's counsel of CIGNA's refusal. Only weeks later, when Mondry's representative followed up with her, did American Family's counsel report the outcome of her inquiry. We know, of course, that CIGNA ultimately was willing to and did produce both the BIRT and CRT to Mondry. The factfinder might conclude that by not taking additional steps on Mondry's behalf to obtain these documents from CIGNA, its agent, American Family contributed to the delay and failed to discharge its fiduciary duty as the plan administrator to provide her with the plan documents to which she was entitled by section 1024(b)(4) and which she needed in order to enforce her rights under the AmeriPreferred Plan.

As against CIGNA, however, we conclude that Mondry does not have a viable claim for restitution based on the delay in providing Plan documents to her. Although CIGNA like American Family was a fiduciary, it did not share American Family's obligation under section 1024(b)(4) to produce Plan documents to Mondry. Mondry has not made a case for imputing to CIGNA a fiduciary duty of disclosure that ERISA itself imposes only on American Family. Moreover, whatever culpability CIGNA might bear for delaying Mondry's appeal by failing to produce the BIRT and CRT to her sooner than it did, CIGNA did not profit from the delay. For as CIGNA rightly points out, it is merely the Plan's claims

administrator. It does not fund the benefit payments – American Family does – and so CIGNA did not stand to gain financially from the delay in reversing its original decision to deny Mondry's claim for benefits.

III.

The district court correctly dismissed Counts One and Two of the complaint as to CIGNA. However, the court erred in entering summary judgment in favor of American Family on these counts. As to Count One, Mondry has established that American Family failed in its statutory obligation to produce plan documents to Mondry under section 1024(b)(4) and therefore is liable for statutory penalties under section 1132(c)(1). The material facts as to that count are not in dispute, and Mondry is entitled to summary judgment finding American Family liable for violating section 1024(b)(4). As to Count Two, Mondry has presented evidence from which the finder of fact could conclude that American Family violated its fiduciary obligation to her by failing to comply with its obligation under section 1024(b)(4). She is entitled to a trial on that count. We therefore reverse the district court's entry of summary judgment in favor of American Family and against Mondry on Counts One and Two and remand with directions to enter summary judgment in favor of Mondry and against American Family on Count One and to determine appropriate statutory penalties, and to conduct such further proceedings

as are appropriate as to Count Two. Mondry shall recover her costs of appeal from American Family.

AFFIRMED IN PART, REVERSED IN PART, and REMANDED.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

SHARON MONDRY,

Plaintiff,

v.

AMERICAN FAMILY MUTUAL INSURANCE COMPANY and AMERIPREFERRED PPO PLAN,

Defendants.

MEMORANDUM AND ORDER

06-C-320-S

(Filed Dec. 12, 2006)

On June 14, 2006 plaintiff Sharon Mondry commenced this civil action against defendants American Family Mutual Insurance Company and AmeriPreferred PPO Plan alleging violations of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, and seeking civil forfeitures and reimbursement of benefits allegedly due under an employee benefit plan governed by ERISA.[1] On October 2, 2006 defendants filed a motion for summary judgment arguing in relevant part that both CIGNA's Clinical Resource Tool and its BIRT document were not statutorily defined Plan documents which defendant

[1] Plaintiff likewise commenced this action against Connecticut General Life Insurance Company. However, on September 26, 2006 the Court entered an order granting Connecticut General's motion to dismiss. Accordingly, the Court dismissed said party from the action.

American Family was obligated to disclose under 29 U .S.C. § 1024(b)(4).[2]

On October 23, 2006 plaintiff filed a brief in opposition to defendants' motion for summary judgment arguing in relevant part that defendant American Family had an obligation to disclose both CIGNA's Clinical Resource Tool and its BIRT document because such documents were "similar in nature" to those specifically enumerated in 29 U.S.C. § 1024 as they assist Plan participants in understanding their rights.

On November 22, 2006 the Court denied defendants' motion for summary judgment as it concerned count one of plaintiff's complaint. The Court determined that both CIGNA's Clinical Resource Tool and its BIRT document were Plan Documents which defendant American Family had an obligation to disclose under 29 U.S.C. § 1024(b)(4).[3]

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[2] Defendants also argued that the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA was not a statutorily defined Plan document. The Court agreed with defendants and found that the 1996 agreement did not fall within the Seventh Circuit's narrow reading of 29 U.S.C. § 1024(b)(4)'s "other instruments" language. Accordingly, the Court determined that defendant American Family had no statutory obligation to disclose said agreement. Neither party disputes this determination.

[3] In its November 22, 2006 Memorandum and Order the Court granted defendants' motion for summary judgment as it concerned count two of plaintiff's complaint finding that

(Continued on following page)

MEMORANDUM

Defendants assert the Court's November 22, 2006 Memorandum and Order conflicts with Seventh Circuit precedent. Additionally, defendants assert both CIGNA's Clinical Resource Tool and its BIRT document are not legally binding. Rather, defendants assert they simply serve as attempts to reasonably construe the formal Plan language of defendant American Family's Summary Plan Description. Accordingly, defendants request that the Court: (1) reconsider its decision denying summary judgment as to count one; and (2) grant summary judgment in their favor dismissing count one of plaintiff's complaint.

Plaintiff asserts the Court correctly determined that even under the Seventh Circuit's narrow interpretation of the "other instruments" language of 29 U.S.C. § 1024(b)(4) both CIGNA's Clinical Resource Tool and its BIRT document are formal documents under which defendant AmeriPreferred PPO Plan is operated. Accordingly, plaintiff argues defendants' motion for reconsideration should be denied.

A. Standard of Review

As a preliminary matter, plaintiff argues defendants' motion should be reviewed under the standard

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defendant American Family did not breach its fiduciary duty. Again, neither party disputes this aspect of the Court's Order.

articulated by the Seventh Circuit in *Bank of Waunakee v. Rochester Cheese Sales, Inc.*, 906 F.2d 1185 (7th Cir. 1990). In *Bank of Waunakee,* the Seventh Circuit determined that a motion for reconsideration performs a valuable function where: (1) a court has patently misunderstood a party, (2) a court has made a decision outside the adversarial issues presented, (3) a court has made an error not of reasoning but of apprehension; or (4) there has been a significant change in the law or facts since submission of the issue to the Court. *Id.* at 1191. Additionally, the Seventh Circuit has determined that a motion to alter or amend a judgment must "clearly establish either a manifest error of law or fact or must present newly discovered evidence." *FDIC v. Meyer,* 781 F.2d 1260, 1268 (7th Cir. 1986) (citation omitted). However, the standard articulated by the Seventh Circuit in *FDIC* concerning motions to alter or amend the judgment is not applicable to defendants' motion because no judgment has been entered in this action.

Rather, defendants' motion is reviewed under the standard articulated by the Seventh Circuit in *Cameo Convalescent Ctr., Inc. v. Percy,* 800 F.2d 108 (7th Cir. 1986). In *Cameo Convalescent Ctr., Inc.,* the Seventh Circuit determined that a district court "has the discretion to make a different determination of any matters that have not been taken to judgment or determined on appeal." *Id.* at 110. Additionally, the Seventh Circuit determined that "[p]re-judgment orders . . . are interlocutory and may be reconsidered at

any time." *Id.* The distinction between the two standards of review makes sense considering the interest courts have in the finality of judgments. However, as previously stated, no final judgment has been entered in this action. Accordingly, the Court maintains discretion to make a different determination on defendants' motion for summary judgment because its November 22, 2006 Memorandum and Order is interlocutory and may be reconsidered at any time before judgment is entered. *Id.*

B. Disclosure of CIGNA's Clinical Resource Tool and its BIRT document under 29 U.S.C. § 1024(b)(4).

Defendants argue CIGNA's internal claims handling guidelines are not contractually binding and as such they are not formal legal instruments under which participant rights are established. Accordingly, defendants argue neither CIGNA's Clinical Resource Tool nor its BIRT document are Plan documents which defendant American Family had an obligation to disclose under Section 1024(b)(4). Plaintiff argues the substance of the requested documents is considered in determining disclosure obligations and as such both CIGNA's Clinical Resource Tool and its BIRT document are Plan documents because they are the types of documents subsumed under the language of Section 1024(b)(4). As the Court stated in its November 22, 2006 Memorandum and order this is a close question. However, after careful consideration, the Court finds that neither CIGNA's Clinical

Resource Tool nor its BIRT document are formal documents that establish or govern a plan. Accordingly, defendants' motion for reconsideration is granted.

Defendants principally rely on the Seventh Circuit's decision in *Egert v. Conn. Gen. Life Ins. Co.*, 900 F.2d 1032 (7th Cir. 1990) to support their argument that CIGNA's internal guidelines are not Plan documents. While the Seventh Circuit's holding in *Egert* is not dispositive because it addressed whether a decision to deny a claim for benefits was arbitrary and capricious rather than whether defendant's internal guidelines were subject to disclosure under Section 1024(b)(4), the Seventh Circuit's discussion of such internal guidelines is helpful to the Court's analysis.

In *Egert,* the Seventh Circuit provided as follows:

> Nonetheless, the treatment of IVF claims by the CCP – a compilation of secret, internal guidelines not disclosed to Canteen or to participants or beneficiaries of the Plan – is not dispositive here. The CCP is not the Plan: it is simply a set of memoranda designed to provide guidance to those interpreting the Plan.

Id. at 1036. In this action, both CIGNA's Clinical Resource Tool and its BIRT document were compilations of private, internal guidelines not disclosed to either defendant American Family or plaintiff. However, it does not necessarily follow that said internal guidelines constitute Plan documents.

Rather, the Court finds that just as the CCP in *Egert* was a set of memoranda designed to provide guidance for plan interpretation, CIGNA's Clinical Resource Tool and its BIRT document were designed to construe the formal Plan language of defendant American Family's Summary Plan Description which is the binding Plan document. Dispositive of the Court's finding is plaintiff's counsel's recognition in his December 21, 2004 letter to CIGNA that the BIRT is not contractually binding. It is difficult to imagine how documents which CIGNA was not contractually obligated to either consult or use when evaluating benefit claims under the Plan could be construed as formal documents that establish or govern the Plan.

Plaintiff is correct in her assertion that CIGNA used its Clinical Resource Tool and its BIRT document to deny her claim for benefits not only initially but also at the appellate level. Additionally, the Court acknowledges that this factor played an important role in its analysis of defendants' motion for summary judgment. However, the Court was not aware of the information contained in plaintiff's counsel's December 21, 2004 letter when it decided defendants' motion for summary judgment because neither party referenced it in their proposed findings of fact or submitted it as evidence during the summary judgment process (although it apparently was attached as an exhibit to plaintiff's complaint.) This evidence alters how the Court views defendant American Family's disclosure obligations. Accordingly, it is now clear that while plaintiff was entitled to these internal

guidelines to ensure a full and fair review of her claim under 29 U.S.C. § 1133(2) she was not entitled to them under 29 U.S.C. § 1024(b)(4).

The Seventh Circuit has determined that the "catch-all" part of 29 U.S.C. § 1024(b)(4) which requires disclosure of "other instruments under which the plan is established or operated" is to be narrowly construed. *Ames v. Am. Nat'l Can Co.*, 170 F.3d 751, 758-759 (7th Cir. 1999). Accordingly, a plan administrator is not required to produce all documents relevant to a plan. *Id.* Rather, a plan administrator has an obligation to disclose only those formal documents that establish or govern a plan. *Id.* at 758. In light of both the Seventh Circuit's narrow construction of 29 U.S.C. § 1024(b)(4) and plaintiff's concession that CIGNA's internal guidelines were not contractually binding the Court finds that defendant American Family did not have a statutory obligation to disclose either CIGNA's Clinical Resource Tool or its BIRT document under 29 U.S.C. § 1024(b)(4) because neither document establishes or governs the Plan. Accordingly, defendants' motion for reconsideration is granted.

ORDER

IT IS ORDERED that defendants' motion for reconsideration is GRANTED.

IT IS FURTHER ORDERED that defendants' motion for summary judgment is GRANTED as it concerns count one of plaintiff's complaint.

IT IS FURTHER ORDERED that judgment is entered in favor of defendants against plaintiff Sharon Mondry dismissing plaintiff's complaint and all claims contained therein with prejudice and costs.

Entered this 12th day of December, 2006.

BY THE COURT:

S/
JOHN C. SHABAZ
District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

SHARON MONDRY,

Plaintiff,

v.

AMERICAN FAMILY MUTUAL INSURANCE COMPANY and AMERIPREFERRED PPO PLAN,

Defendants.

MEMORANDUM AND ORDER

06-C-320-S

(Filed Nov. 22, 2005)

Plaintiff Sharon Mondry commenced this civil action against defendants American Family Mutual Insurance Company and AmeriPreferred PPO Plan alleging violations of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, and seeking civil forfeitures and reimbursement of benefits allegedly due under an employee benefit plan governed by ERISA.[1] Jurisdiction is based on 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e). The matter is presently before the Court on defendants' motion for

[1] Plaintiff also commenced this action against Connecticut General Life Insurance Company. However, on September 26, 2006 the Court entered an order granting Connecticut General's motion to dismiss. Accordingly, the Court dismissed said party from the action. Additionally, on said date the Court granted defendant American Family Mutual Insurance Company's motion to dismiss counts three through six of plaintiff's complaint. As such, only counts one and two of plaintiff's complaint remain which allege ERISA violations.

summary judgment. The following facts are either undisputed or those most favorable to plaintiff.

FACTS

Defendant AmeriPreferred PPO Plan (hereinafter the Plan) is a self-insured group health insurance plan offered by defendant American Family Mutual Insurance Company (hereinafter American Family) to its employees. Plaintiff Sharon Mondry was an employee of defendant American Family and participated in the Plan. At all times relevant to this action, defendant American Family was designated as the Plan Administrator while Connecticut General Life Insurance Company (hereinafter CGLIC) served as the Plan's Claims Administrator. CGLIC is an affiliate of CIGNA Corporation and CIGNA Health Care Group (hereinafter collectively referred to as CIGNA.) CGLIC was granted discretionary authority for making claim determinations. Defendant American Family did not actively participate in the claims determination process.

In the year 2003, plaintiff's son Zevee Mondry received speech therapy services from Communication Development Center. Accordingly, plaintiff submitted a claim in which she requested that the Plan cover her son's speech therapy services. On June 15, 2003 CIGNA (by letter) notified both plaintiff and Communication Development Center of its decision to deny coverage for Zevee Mondry's speech therapy services

as not medically necessary. Said letter provides in relevant part as follows:

> . . . Your plan provides coverage for specified Covered Services which are medically necessary. After a review of the information submitted, we have determined that the requested services are not covered under the terms of your plan. This coverage decision was made based on the following:
>
> The information provided does not meet plan language for speech therapy per CIGNA guidelines. . . . Speech therapy is not restorative. Based on CIGNA's Benefit Resource Tools Guidelines-Speech Therapy. . . .

On June 30, 2003 plaintiff (by letter) notified both CIGNA and defendant American Family of her decision to appeal CIGNA's claim denial. Said letter provides in relevant part as follows:

> . . . I am attaching a copy of a denial letter I recently got from CIGNA for speech therapy for my son.
>
> I want to appeal the denial, and am requesting a complete copy of my Plan Documents. The document I was told to pull off the American Family Intranet site is a Summary Plan Description, and is incomplete.

On July 23, 2003 CIGNA notified plaintiff by letter of its decision to uphold its initial adverse benefit determination. Said letter provides in relevant part as follows:

> . . . we have decided to uphold the original decision to maintain denial of Zev's Speech therapy as not medically necessary.
>
> The decision was based on the following:
>
> . . . Speech therapy, which is not restorative, is not a covered expense per the patient's specific plan provisions.
>
> Reference CIGNA Clinical resource tool for Speech Therapy.
>
> . . . You are entitled to receive free of charge, upon request, copies of all documents, records and other information relevant to your appeal for benefits. . . .

Accordingly, CIGNA's letter demonstrates that it based its decision to uphold the original denial of plaintiff's claim on its Clinical Resource Tool for Speech Therapy. As such, this information was relevant to both plaintiff's claim and to any second-level appeal for benefits.

On July 28, 2003 plaintiff submitted an additional written request for documents to both CIGNA and defendant American Family. Her letter provides in relevant part as follows:

> . . . I first wrote on June 30, 2003 requesting a complete copy of my CIGNA plan documents. Your response of July 11, 2003 unfortunately does not respond to my request. All copies are attached.

> *I am again requesting the total and complete copy of my Plan Documents.*

Additionally, plaintiff's submission included copies of all prior communication occurring between her, CIGNA, and defendant American Family.

On September 23, 2003 plaintiff's attorney wrote a letter to both CIGNA and defendant American Family in which he again requested Plan documents.[2] Said letter provides in relevant part as follows:

> . . . On June 30 and July 28, 2003 [plaintiff] requested the complete plan document used as the premise for denying coverage for her son Zev . . .
>
> . . . Please immediately provide a copy of the plan document in effect at the time the coverage was denied for this claim . . .
>
> If you are not the Plan Administrator, please forward this letter to that person and correspond to the undersigned with the name and contact information of that person.

On October 16, 2003 Ms. Stacy McDaniel, Benefits Specialist for defendant American Family, responded (by letter) to plaintiff's attorney's request. Said letter provides in relevant part as follows:

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[2] The letter from plaintiff's attorney is actually dated September 23, 2002. However, given the timing of events in this action the Court presumes said date should read September 23, 2003.

> American Family Insurance received communication from Jonathan Cope concerning a copy of the CIGNA Plan document. I have enclosed a copy of the AmeriPreferred Summary Plan Description. This Summary Plan Description is the Plan document; we do not have a separate plan document.
>
> This document was made available to you both in paper and electronically while you were an active employee. A paper copy was also provided to you based on an earlier request. . . .

Plaintiff disputes that defendant American Family provided her with a paper copy of the Summary Plan Description based upon her earlier requests. However, plaintiff concedes that she received a paper copy during her term of employment with defendant American Family which ultimately terminated on October 2, 2003.

On October 30, 2003 plaintiff's attorney submitted a fourth written request for documents to CIGNA. Defendant American Family was copied into his letter. Said letter provides in relevant part as follows:

> On June 30 and July 28, 2003 [plaintiff] requested the complete plan document used for denying coverage to her son Zev. . . . By way of response, she has been told several times to go to an online site where she can access the plan document electronically.

The only document available to her is the AmeriPreferred PPO Summary Plan Description. As Jonathan M. Cope, Attorney-ABC for Health, Inc., requested the complete plan document again on September 23, 2003, and has received no response from CIGNA, we must conclude that the Summary Plan Description was the legally binding document used as the premise for denying coverage . . . American Family Insurance responded to Mr. Cope's request for a plan document on October 16, 2003, stating that there is no separate plan document. As of today, CIGNA has not responded to our request. Please advise us if this information about the plan document is incorrect, and if so, please immediately provide a copy of the legally binding plan document in effect at the time that coverage was denied for this claim. Please reference the specific language relied on in the plan document to deny coverage and forward a copy of that plan to the undersigned within 30 days. . . .

Prior to that request, a denial letter dated July 23, 2003, enclosed herein and addressed to [plaintiff,] referenced a CIGNA Clinical Resource Tool for Speech Therapy. This Clinical Resource Tool is not included in the AmeriPreferred PPO Summary Plan Description available to [plaintiff.] This letter, signed by Dr. Patricia J. Loudis, MD, states [plaintiff] is entitled to receive, free of charge, and upon request, copies of all documents, records, and other information relevant to her appeal for benefits. We are

> also requesting this Clinical Resource Tool, as well as any other information used to make your decision to deny these services, be sent to the undersigned. . . .

On January 7, 2004 (approximately three months later) plaintiff's attorney again wrote to both CIGNA and defendant American Family concerning plaintiff's requests for Plan documents. Said letter provides in relevant part as follows:

> . . . A summary of the health insurance contract in the form of a Summary Plan Description is not sufficient and is not what has been repeatedly requested. . . .
>
> . . . CIGNA has been made well aware of the fact that American Family Insurance has failed to provide the complete plan document, as CIGNA and American Family Insurance have both been contacted with each request made by ABC for Health and [plaintiff.] CIGNA also ignored several requests for the CIGNA Clinical Resource Tool for Speech Therapy and copies of all documents, records, and other information relevant to [plaintiff's] appeal for benefits. . . .
>
> All correspondence dated October 30, 2003 and later is enclosed herein. All correspondence prior to October 2003 that is referenced in this . . . letter was enclosed in the October 30, 2003 letter sent to CIGNA and copied to American Family Insurance, except for the July 13, 2003 denial letter, which is

> enclosed herein. . . . Please immediately provide a copy of the legally binding plan document in effect at the time the coverage was denied for this claim, a copy of the above-mentioned Clinical Resource Tool, as well as any other information used to make the decision to deny these services. . . .

Plaintiff thereafter received a packet of information from CIGNA which her attorney determined was an insufficient response to her requests. Accordingly, on January 28, 2004 plaintiff's counsel submitted a sixth written request for documents to CIGNA. Defendant American Family was again copied into his letter. Said letter provides in relevant part as follows:

> . . . you have again failed to provide the information requested, which is the plan language used as the premise for CIGNA's denial of Zev Mondry's speech therapy. As you must know, this makes it impossible to prepare for a second level appeal. . . .
>
> To remind you of the specific information requested, we are enclosing our prior three requests for this language, as well as CIGNA's denial letter dated July 23, 2003 and two CIGNA printable reports dated June 10, 2003 and July 23, 2003. These documents refer to a CIGNA Clinical resource tool for Speech Therapy and to CIGNA's specific plan provisions. The words "Expressive Language Delays" are not found in the Summary Plan Document, and so they must exist somewhere in plan documents that have been withheld from [plaintiff.] . . .

The next series of relevant communication occurring between plaintiff, CIGNA, and defendant American Family began on April 21, 2004 when Ms. Kathryn Kehoe, legal intern at ABC for Health, faxed another request for Plan documents to defendant American Family. Said transmission provides in relevant part as follows:

> . . . I am also sending prior requests for information. We have not yet received a plan document from American Family or Cigna. We have been relying on a Summary Plan Description from an online site. We still require a plan document as well as the rules, guidelines, or protocols used as the premise for the denial of services. . . .

Additionally, on said date, Ms. Kehoe left a telephone voice message for Ms. Rosalie Beck Detmer, Assistant General Counsel for defendant American Family, in which she requested a hard copy of the Clinical Resource Tool for Speech Therapy referenced in CIGNA's denial letter. Ms. Detmer responded by advising Ms. Kehoe that she would contact CIGNA and request that it provide plaintiff with a copy of the Clinical Resource Tool used to evaluate her claim. Additionally, Ms. Detmer indicated that the Summary Plan Description was the only Plan document and neither CIGNA nor defendant American Family had another Plan document.

On April 23, 2004 Ms. Kehoe again communicated with Ms. Detmer by telephone. Ms. Detmer advised Ms. Kehoe that she would contact CIGNA

and attempt to obtain a copy of its Clinical Resource Tool for plaintiff. Indeed, Ms. Detmer contacted CIGNA on said date and requested that it provide plaintiff with a copy of its Clinical Resource Tool for Evaluating Speech Therapy. However, CIGNA's representative Mr. Carl Peterson informed Ms. Detmer that its Resource Tool was proprietary and CIGNA would not release such information to either plaintiff or defendant American Family. Additionally, Mr. Peterson advised Ms. Detmer that CIGNA's Clinical Resource Tool was "too big to send anyway" and the Summary Plan Description was the only document either party was legally required to provide to plaintiff.

On May 20, 2004 Ms. Detmer informed Ms. Kehoe (by telephone) that CIGNA refused to release its Clinical Resource Tool to either plaintiff or defendant American Family. However, Ms. Detmer provided Ms. Kehoe with Mr. Peterson's name and telephone number. It is undisputed that defendant American Family never requested nor encouraged CIGNA to withhold such information from plaintiff. Additionally, it is undisputed that defendant American Family never possessed a copy of CIGNA's Clinical Resource Tool.

Subsequent to May 20, 2004 plaintiff ceased communications with defendant American Family and instead continued to communicate solely with CIGNA concerning documents related to her appeal. It is undisputed that defendant American Family provided only one written response to plaintiff's

requests for Plan documents. Additionally, it is undisputed that the only Plan document defendant American Family provided to plaintiff was a copy of the Summary Plan Description.

On October 5, 2004 CIGNA provided plaintiff's attorney with a copy of its HealthCare Benefit Interpretation Resource Tool for GSA 2001 Requested Service: Speech Therapy (hereinafter BIRT document.) Said BIRT document provides that coverage for speech therapy services is governed in part by the standard benefit plan language defining medically necessary/medical necessity. The BIRT document defines medically necessary as follows:

> Medically necessary covered Services and Supplies are those Services and Supplies that are determined by the Healthplan Medical Director to be:
>
> No more than required to meet your basic needs; and Consistent with the diagnosis of the condition for which they are required; and
>
> Consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
>
> Required for purposes other than comfort and convenience of the patient or his Physician; and
>
> Rendered in the least intensive setting that is appropriate for the delivery of health care; and Of demonstrated medical value.

Additionally, the BIRT document provides that "[s]peech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature." Further, the BIRT document states that "[t]he Clinical Resource Tool presents more detailed information, background, and references regarding Speech Therapy." Finally, CIGNA's Clinical Resource Tool (provided to plaintiff during discovery) indicates what type of objective clinical information may be required to support "the medical necessity of speech therapy." Such clinical information includes: diagnostic test complete speech therapy records, medical necessity narrative from an attending physician, and reports of standardized speech tests.

However, the Summary Plan Description defines "Medically Necessary" as follows:

> In addition to the reasonable and customary limits, to be eligible for Plan payment, medical services and supplies must be considered by CIGNA to be "Medically Necessary." For purposes of this plan, Medically Necessary means that services and supplies are provided by a hospital, doctor, or other licensed medical provider to treat a covered illness or injury. The treatment must be appropriate for the symptoms or diagnosis, within the standards of acceptable medical practice, the most appropriate supply or level safe for the patient, and not solely for the convenience of

> the patient, doctor, hospital, or other licensed professional.

Additionally, the Summary Plan Description provides that "[i]n general, the following medical services or supplies are covered by the Plan . . . [p]hysical, occupational or speech therapy if performed by a licensed or certified therapist and if referred by a doctor."

On April 13, 2005 CIGNA conducted a level-two appeal hearing on plaintiff's claim for benefits. After this hearing, CIGNA reversed both its initial denial and its level-one appellate decision and authorized reimbursement for speech therapy services provided to Zevee Mondry. Accordingly, plaintiff received checks from CIGNA reimbursing her in the amount of $3,056.11 for speech therapy services provided to her son between January 1, 2003 and October 2, 2003.

On June 14, 2006 plaintiff commenced this action alleging that defendant American Family failed to provide her with a copy of the contract or other instrument under which the Plan was established or operated. Additionally, plaintiff alleges that defendant American Family breached its fiduciary duties by misrepresenting the terms and administration of the Plan and by withholding information necessary to defend her claim and perfect her appeal.

MEMORANDUM

Defendants acknowledge that plan administrators have a statutory obligation to provide their participants with copies of Summary Plan Descriptions, trust agreements, contracts, or other instruments under which an ERISA plan is established or operated. However, defendants assert the documents at issue, CIGNA's Resource Tools and the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA, are not statutorily defined Plan documents which defendant American Family was under an obligation to provide. Accordingly, defendants argue defendant American Family complied with its disclosure obligation when it provided plaintiff with a copy of the Summary Plan Description. As such, defendants argue their motion for summary judgment should be granted as it concerns count one. Additionally, defendants argue their motion for summary judgment should be granted as it concerns count two because plaintiff is seeking purely legal remedies in this action where only equitable relief is available. Alternatively, defendants argue their motion for summary judgment should be granted as it concerns count two because defendant American Family did not breach any fiduciary duty.

Plaintiff asserts defendant American Family had an obligation to disclose CIGNA's Resource Tools and the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA because such documents are "similar in nature" to those

specifically enumerated in 29 U.S.C. § 1024 as they assist Plan participants in understanding their rights. Accordingly, plaintiff argues defendants' motion for summary judgment should be denied as it concerns count one. Additionally, plaintiff asserts defendant American Family breached its fiduciary duty by failing to disclose complete and accurate information concerning her status as a Plan participant. Further, plaintiff asserts she is seeking equitable relief in this action such as retroactive reinstatement of coverage. Accordingly, plaintiff argues defendants' motion for summary judgment should be denied as it concerns count two.

A. Standard of Review

Summary judgment is appropriate where the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

A fact is material only if it might affect the outcome of the suit under the governing law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 2510, 91 L.Ed.2d 202 (1986). Disputes over unnecessary or irrelevant facts will not preclude summary judgment. *Id.* Further, a factual issue is genuine only if the evidence is such that a reasonable fact finder could return a verdict for the non-moving party. *Id.* A court's role in summary judgment is not

to "weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Id.* at 249, 106 S.Ct. at 2511.

To determine whether there is a genuine issue of material fact for trial courts construe all facts in the light most favorable to the non-moving party. *Heft v. Moore,* 351 F.3d 278, 282 (7th Cir. 2003) (citation omitted). Additionally, a court draws all reasonable inferences in favor of that party. *Id.* However, the non-movant must set forth "specific facts showing that there is a genuine issue for trial" which requires more than "just speculation or conclusory statements." *Id.* at 283 (citations omitted). If a court determines that the material facts are not in dispute then the "sole question is whether the moving party is entitled to judgment as a matter of law." *Santaella v. Metro. Life Ins. Co.,* 123 F.3d 456, 461 (7th Cir. 1997) (citation omitted).

B. Count One – Violation of 29 U.S.C. § 1024(b)(4) – Failure to Provide Required Information

Count one of plaintiff's complaint is governed by 29 U.S.C. § 1024(b)(4) which provides in relevant part as follows:

> The administrator shall, upon written request of any participant[3] or beneficiary, furnish

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[3] Participant in the context of ERISA is defined as (as is relevant to this action) "former employees who have a reasonable expectation of returning to covered employment or

(Continued on following page)

> a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. . . .

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who have a colorable claim to vested benefits." *Winchester v. Pension Comm. of Michael Reese Health Plan, Inc. Pension Plan,* 942 F.2d 1190, 1192-1193 (7th Cir. 1991) (citation omitted). It is undisputed that plaintiff is no longer employed by defendant American Family and there is no suggestion that she has a reasonable expectation of returning to covered employment. Additionally, plaintiff is not seeking a benefit from an employee benefit plan under count one. Rather, she is seeking damages under a penalty provision. Accordingly, at first glance it appears that plaintiff does not have standing to bring her cause of action under Section 1024(b)(4). However, the Seventh Circuit has stated that there is some merit in allowing former employees to bring actions against an administrator for failure to provide information within a reasonable amount of time after receiving vested benefits. *Id.* at 1193. Plaintiff was reimbursed for her son's speech therapy services on March 2, 2006 and she commenced this action on June 14, 2006. The Court finds this is a reasonable amount of time for plaintiff to commence an action under Section 1024 especially in light of the fact that plaintiff made numerous requests for information both before terminating her employment with defendant American Family and before her claim was ultimately approved. Accordingly, the Court finds that plaintiff has standing to bring this action. In any event, defendants failed to object to plaintiff's standing in their motion for summary judgment. As such, they have waived any argument they may have had on this issue. *Milwaukee Area Joint Apprenticeship Training Comm. for the Elec. Indus. v. Howell,* 67 F.3d 1333, 1337 (7th Cir. 1995) (citation omitted).

Penalties for violations of Section 1024(b)(4) are imposed pursuant to 29 U.S.C. § 1132(c)(1)(B) which provides in relevant part as follows:

> Any administrator . . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant . . . by mailing the material requested to the last known address of the requesting participant . . . within 30 days after such request may in the court's discretion be personally liable to such participant . . . in the amount of up to $100 a day from the date of such failure or refusal . . .

Once a participant submits a written request for documents under Section 1024(b)(4) a plan administrator must respond so long as the participant's request provides clear notice of what information he or she desires. *Anderson v. Flexel, Inc.*, 47 F.3d 243, 248 (7th Cir. 1995) (citations omitted). However, while a participant's request for information must be clear, an administrator's knowledge of either the surrounding circumstances or the information being requested may require a response to an otherwise general request. *Id.* (citations omitted). Additionally, a participant need not ask for specific documents by name and an administrator cannot use such "technical considerations as an excuse for its failure to respond." *Id.* at 250 (citation omitted).

As previously stated, pursuant to Section 1132(c)(1)(B), a plan administrator has thirty-days to

respond to a participant's written request for information and a court (in its discretion) may impose penalties of up to $100 a day from the date on which the administrator either failed or refused to respond. The underlying purpose of Section 1132(c)(1)(B) "is not so much to penalize as to induce plan administrators to respond in a timely manner to a participant's request for information." *Winchester,* at 1193. Accordingly, when determining whether to award a penalty for disclosure violations courts should consider both the "conduct and intent of the [plan] administrator in not providing the relevant information" and "the harm or prejudice suffered by the participant." *Hess v. Hartford Life and Acc. Ins. Co.,* 91 F.Supp.2d 1215, 1224 (C.D.Ill.2000) (citation omitted), *aff'd,* 274 F.3d 456 (7th Cir. 2001).

In this action, the documents at issue are CIGNA's Resource Tools (both its Clinical Resource Tool and its BIRT document) and the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA. Defendants argue that none of these documents fall within the disclosure requirements of Section 1024(b)(4). However, all parties agree that defendants are liable for statutory penalties only if the Court finds that these three documents fall within the "other instruments under which the plan is established or operated" language of 29 U.S.C. § 1024(b)(4).

The Seventh Circuit has determined that the "catch-all" part of 29 U.S.C. § 1024(b)(4) which requires disclosure of "other instruments under which the plan

is established or operated" is to be narrowly construed. *Ames v. Am. Nat'l Can Co.*, 170 F.3d 751, 758-759 (7th Cir. 1999). Accordingly, a plan administrator is not required to produce all documents relevant to a plan. *Id.* Rather, a plan administrator has an obligation to disclose only those formal documents that establish or govern a plan. *Id.* at 758.

When determining whether certain documents establish or govern a plan courts consider whether such documents "allow the individual participant [to] know [ ] exactly where [s]he stands with respect to the plan – what benefits [s]he may be entitled to, what circumstances may preclude [her] from obtaining benefits, what procedures [she] must follow to obtain benefits, and who are the persons to whom the management and investment of [her] plan funds have been entrusted." *Hess*, at 1226 (citation and internal quotation marks omitted). Accordingly, with the legal framework in place, the Court will determine whether the three documents at issue were subject to disclosure under Section 1024(b)(4) beginning with the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA.

Plaintiff argues that she was entitled to the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA (hereinafter the 1996 agreement) because it is a plan document containing information relevant to her appeal for benefits. The Court does not agree. The 1996 agreement defines the terms whereby CIGNA agreed to furnish claims administration services to defendant

American Family. Specifically, the 1996 agreement: (1) provides the amount CIGNA charges defendant American Family for its services, (2) outlines the length of time it is to remain in effect; and (3) defines what laws govern its operation. However, what is most important to the Court's determination is not what is actually contained within the language of the 1996 agreement. Rather, the factor the Court finds dispositive is what is absent from the language of the 1996 agreement as it fails to define what rights or benefits are available to the Plan's participants and beneficiaries. Accordingly, while the 1996 agreement may be relevant to the Plan it does not fall within the Seventh Circuit's narrow reading of Section 1024(b)(4)'s "other instruments" language. As such, defendant American Family had no obligation to disclose the 1996 agreement under 29 U.S.C. § 1024(b)(4). *Ames,* at 758-759.

Additionally, plaintiff argues that she was entitled to both CIGNA's Clinical Resource Tool for Speech Therapy and its BIRT document because such documents are similar in nature to documents expressly subject to Section 1024(b)(4)'s disclosure requirements. Defendants argue these documents are not organic documents underpinning the Plan. Rather, they argue these documents are internal rules and guidelines which are not subject to disclosure under Section 1024(b)(4). This is a close question. However, the Court finds that even under the Seventh Circuit's narrow reading of Section 1024(b)(4) these documents

are the type of formal documents under which the plan is operated.

CIGNA's Clinical Resource Tool indicates what type of objective clinical information may be required to support "the medical necessity of speech therapy." Such clinical information includes: diagnostic test results, complete speech therapy records, medical necessity narrative from an attending physician, and reports of standardized speech tests. Additionally, the BIRT document not only defines medically necessary/ medical necessity but it also provides that "[s]peech therapy is not covered when (a) used to improve skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature." Accordingly, these documents allowed plaintiff to know: (1) what circumstances precluded her from obtaining benefits under the plan; and (2) what procedures she needed to follow to obtain benefits under the plan i.e. what type of objective clinical information she needed to submit in support of the "medical necessity" element of her claim. *Hess,* at 1226.

Additionally, CIGNA denied plaintiff's claim for benefits based on these documents not only initially but also at the appellate level. For example, CIGNA's June 15, 2003 denial letter provides that plaintiff's claim was denied because Zevee's "[s]peech therapy [wa]s not restorative. Based on CIGNA's Benefit Resource Tools Guidelines – Speech Therapy." Additionally, CIGNA's July 23, 2003 letter provides that

its decision to uphold its initial adverse benefit determination was based on the following: "[s]peech therapy, which is not restorative, is not a covered expense per the patient's specific plan provisions. Reference CIGNA Clinical resource tool for Speech Therapy." However, the Summary Plan Description fails to specifically provide that speech therapy is not a covered expense when it is not restorative. Rather, the Summary Plan Description provides that "[i]n general, the following medical services or supplies are covered by the Plan . . . [p]hysical, occupational or speech therapy if performed by a licensed or certified therapist and if referred by a doctor." Accordingly, it is clear that both CIGNA's Clinical Resource Tool for Speech Therapy and its BIRT document (and not solely the Summary Plan Description) govern when speech therapy claims are approved under the Plan. As such, these documents govern plan operation and were subject to disclosure under Section 1024(b)(4).

The facts of this action are distinguishable from the situation in *Hess* where plaintiff claimed that she was entitled to (among other items) a copy of her LTD data form. *Id.* at 1227. The Court in *Hess* determined that plaintiff's claim failed because the LTD data form was used simply to transmit information pertinent to her particular claim such as her name and social security number, her level of insurance benefits, and her yearly salary. *Id.* However, the facts of this action demonstrate that the Clinical Resource Tool and the BIRT document are used by CIGNA to evaluate all speech therapy claims submitted to the

Plan. Accordingly, both documents were formal legal instruments governing the plan's operation or management. *Id.* As such, plaintiff was entitled to these documents within thirty-days of her first clear request which the Court finds was her initial request made on June 30, 2003.

In her June 30, 2003 letter plaintiff advised both defendant American Family and CIGNA that she was requesting a complete copy of her Plan Documents which includes both CIGNA's Clinical Resource Tool and its BIRT document. Additionally, plaintiff attached a copy of CIGNA's June 15, 2003 denial letter which specifically referenced CIGNA's BIRT document. While plaintiff's June 30, 2003 letter failed to request either the Clinical Resource Tool or the BIRT document by name, an administrator cannot use such "technical considerations as an excuse for its failure to respond." *Anderson,* at 250 (citation omitted). Additionally, imposing a burden upon plaintiff to ask for documents by name rather than by description would be "contrary to the spirit of § 1024(b)(4)." *Id.* Accordingly, the Court finds that plaintiff's June 30, 2003 letter provided defendant American Family with notice of which documents she desired. As such, this letter triggered the thirty-day limitations period to respond pursuant to 29 U.S.C. § 1132(c)(1)(B).

Defendants argue they should not be held liable for violations of 29 U.S.C. § 1024(b)(4) as they relate to these documents because defendant American Family never possessed them and it would be impossible to disclose documents it never had. It is

undisputed that defendant American Family never possessed these documents. However, 29 U.S.C. § 1024(b)(4) does not contain any language which suggests that a plan administrator's statutory obligation to furnish documents is limited to furnishing only those documents which are actually in its possession. Rather, the language of the statute provides that:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. . . .

29 U.S.C. § 1024(b)(4). Accordingly, said statute imposes a mandatory obligation on plan administrators to disclose documents that fall within the statutory language regardless of whether the administrator actually possesses such documents. As such, the Court must find defendants liable for violating 29 U.S.C. § 1024(b)(4). Accordingly, defendants' motion for summary judgment is denied as it concerns count one of plaintiff's complaint. Both CIGNA's Clinical Resource Tool and its BIRT document are Plan documents which defendant American Family had an obligation to disclose under 29 U.S.C. § 1024(b)(4).

Courts can in appropriate cases "grant summary judgment for the non-moving party even though it made no formal cross-motion under Rule 56." *Lett v.*

Magnant, 965 F.2d 251, 261 (7th Cir. 1992) (citations omitted). However, the Court finds that it is not appropriate to do so in this action. While the Court found that both CIGNA's Clinical Resource Tool and its BIRT document are Plan documents subject to the disclosure requirements of 29 U.S.C. § 1024(b)(4) issues of material fact remain concerning when plaintiff received CIGNA's Clinical Resource Tool. It is undisputed that plaintiff received the BIRT document from CIGNA on October 5, 2004. However, the only information submitted to the Court concerning the Clinical Resource Tool is that plaintiff received it during discovery. An exact date was not provided.

Additionally, issues of material fact remain concerning what harm or prejudice (if any) plaintiff suffered as a result of defendant American Family's failure to disclose. *Hess,* at 1224 (citations omitted). On March 2, 2006 plaintiff was reimbursed for expenses associated with her son's speech therapy services. While plaintiff alleges a balance of $303.89 remains outstanding, the Court does not know whether plaintiff is entitled to this allegedly outstanding balance or why she has not received this balance if she is entitled to it. Accordingly, issues of material fact remain concerning whether a penalty should be awarded to plaintiff for defendant American Family's disclosure violations. As such, the Court cannot grant

summary judgment in plaintiff's favor as it concerns count one of her complaint.[4]

C. Count Two - Violation of 29 U.S.C. § 1104(a)(1) - Breach of Fiduciary Duty

Under ERISA, a fiduciary is an entity that has discretionary authority over assets of an ERISA plan. *Rud v. Liberty Life Assur. Co. of Boston,* 438 F.3d 772, 774 (7th Cir. 2006) (citations omitted). Classification as an ERISA fiduciary serves an important function because ERISA mandates that a fiduciary "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Defendants do not dispute that defendant American Family is a fiduciary as such term is defined under ERISA. Additionally, defendants do not dispute that defendant American Family as a fiduciary must comply with Section 1104(a)(1). Rather, defendants argue that defendant American Family did not breach any fiduciary duty owed to plaintiff. Accordingly, defendants argue their motion for summary judgment should be granted as it concerns count two.

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[4] An additional factor the Court considers in determining whether to award a penalty is the "conduct and intent of the [plan] administrator in not providing the relevant information." *Hess,* at 1224 (citations omitted). The facts of this action clearly demonstrate that defendant American Family did not intend to deprive plaintiff of information. Rather, it attempted to obtain a copy of the Plan documents from CIGNA on plaintiff's behalf.

Fiduciaries breach their duties of loyalty and care "if they mislead plan participants or misrepresent the terms or administration of a plan." *Anweiler v. Am. Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir. 1993) (*citing Berlin v. Mich. Bell Tel. Co.*, 858 F.2d 1154, 1163 (6th Cir. 1988) (listing cases)). Additionally, fiduciaries must disclose material facts affecting the interests of plan participants. *Kamler v. H/N Telecomm. Services, Inc.*, 305 F.3d 672, 681 (7th Cir. 2002) (*citing Bowerman v. Wal-Mart Stores, Inc.*, 226 F.3d 574, 590 (7th Cir. 2000)). This obligation exists when a beneficiary asks for information and "even when he or she does not." *Anweiler,* at 991 (citation omitted). However, not every error in communicating information concerning a plan violates a fiduciary's duty under ERISA. *Bowerman,* at 590 (citations omitted). Additionally, plaintiff must allege that the breach of fiduciary duty "caused some harm to him or her that can be remedied." *Kamler,* at 681.

Plaintiff argues defendant American Family breached its fiduciary duty because it: (1) willingly declined to provide complete and accurate plan information, (2) promulgated misleading information in response to plaintiff's inquiries when it knew or should have known that such information would be misleading; and (3) elected to subjugate plaintiff's interests to its own. However, the facts of this action demonstrate that defendant American Family did not breach its fiduciary duty. Accordingly, defendants' motion for summary judgment is granted as it concerns count two.

Plaintiff argues defendant American Family willingly declined to provide complete and accurate plan information. However, the facts of this action clearly demonstrate the opposite. First, it is undisputed that defendant American Family never requested nor encouraged CIGNA to withhold its Resource Tools from plaintiff. Additionally, on April 23, 2004 Ms. Detmer, Assistant General Counsel for defendant American Family, contacted CIGNA and attempted to obtain a copy of its Clinical Resource Tool for plaintiff. Further, on May 20, 2004 Ms. Detmer informed Ms. Kehoe (legal intern at ABC for Health) that CIGNA refused to release its Clinical Resource Tool to either defendant American Family or plaintiff. However, Ms. Detmer provided Ms. Kehoe with Mr. Peterson's contact information at CIGNA. These facts establish that defendant American Family did not willingly withhold information from plaintiff. Rather, they demonstrate that defendant American Family attempted to obtain the documents plaintiff requested. While its attempt was unsuccessful, it does not negate the fact that defendant American Family intervened on plaintiff's behalf.

Additionally, plaintiff argues defendant American Family promulgated misleading information in response to plaintiff's inquiries when it knew or should have known that such information would be misleading. It is undisputed that defendant American Family provided only one written response to plaintiff's request for Plan documents which was its

letter of October 16, 2003. Said letter provides as follows:

> American Family Insurance received communication from Jonathan Cope concerning a copy of the CIGNA Plan document. I have enclosed a copy of the AmeriPreferred Summary Plan Description. This Summary Plan Description is the Plan document; we do not have a separate plan document.

While the information contained within defendant American Family's letter was incorrect (because the Court found that CIGNA's Clinical Resource Tool and its BIRT document are also Plan documents) not every error in communicating information concerning a plan violates a fiduciary's duty under ERISA. *Bowerman,* at 590 (citations omitted). Additionally, the facts of this action clearly demonstrate that plaintiff was not harmed by defendant American Family's incorrect statement because she was not misled by its October 16, 2003 letter. This is evidenced by the fact that she made four additional requests for documents subsequent to said date. Accordingly, the Court finds that defendant American Family did not mislead plaintiff into believing that the Summary Plan Description was the only plan document. *Anweiler,* at 991 (citation omitted). As such, plaintiff failed to demonstrate that defendant American Family "caused some harm to [ ] her that can be remedied." *Kamler,* at 681.

Finally, plaintiff argues defendant American Family elected to subjugate plaintiff's interests to its

own when it made an "affirmative decision to minimize its investment of staff resources in pursuit of rectifying [plaintiff's] confusion about the source and application of the alleged 'specific plan provisions' that barred coverage of Zev's speech therapy services." (Pl.'s Br. Opp'n Defs.' Mot. Summ. J. page 12, lines 3-5). However, plaintiff failed to submit any evidence in support of her position other than conclusory statements contained within her opposition brief. To successfully defeat defendants' motion for summary judgment on the breach of fiduciary duty issue plaintiff must set forth "specific facts showing that there is a genuine issue for trial" which requires more than "just speculation or conclusory statements." *Heft*, at 283 (citations omitted). Plaintiff failed to do so with respect to her argument that defendant American Family elected to subjugate her interests to its own. Accordingly, defendants' motion for summary judgment is granted as it concerns count two of plaintiff's complaint.[5]

ORDER

IT IS ORDERED that defendants motion for summary judgment is GRANTED as it concerns

[5] Because the Court determined that defendant American Family did not breach its fiduciary duty, it need not reach defendants' argument that plaintiff seeks impermissible legal remedies under 29 U.S.C. § 1132(a)(3).

count two of plaintiff's complaint and in all other respects is DENIED.

Entered this 21st day of November, 2006.

BY THE COURT:

s/
JOHN C. SHABAZ
District Judge

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

April 2, 2009

Before

JOEL M. FLAUM, *Circuit Judge*

MICHAEL S. KANNE, *Circuit Judge*

ILANA DIAMOND ROVNER, *Circuit Judge*

No. 07-1109

SHARON MONDRY,
Plaintiff-Appellant,

v.

AMERICAN FAMILY MUTUAL INSURANCE COMPANY, *et al.*,
Defendants-Appellees.

Appeal from the United States District Court for the Western District of Wisconsin.

No. 06-C-320

John C. Shabaz, *Judge*.

ORDER

No judge of the court having called for a vote on the Petition For Hearing and Suggestion For Rehearing En Banc filed by Defendants-Appellees on March 19, 2009, and all of the judges on the original panel having voted to deny the same,

IT IS HEREBY ORDERED that the Petition for Rehearing and Suggestion For Rehearing En Banc is **DENIED**.